

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10994

11028

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>July</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>25yr6mth4dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Abey</u> Last <u>Abey</u>		4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1869</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gregory Bopp</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Seibel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia, arteriosclerotic vascular disease.</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 18, 1959</u> to <u>Oct. 21, 1959</u> that I last saw the deceased alive on <u>Oct. 21, 1959</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>10/21/59</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADDAUSKAS</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	22d. LOCATION (City, town, or county) (State) <u>A.A. Co (Brooklyn) Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemuel J. Luck</u> ADDRESS <u>5305 Harford.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

CERTIFICATE OF DEATH

PAID BY STATE

PAID BY STATE

PAID BY STATE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10992

Reg. Dist. No.

11029

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>22 Nunnery Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Annetta</b> Last <b>Airey</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 24, 1879</b>		9. AGE (In years last birthday) <b>79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Heiland</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Ferrer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>--</b>		17. INFORMANT Address <b>Hiram Airey - 22 Nunnery Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio vascular disease</b> DUE TO <b>350X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Parkinsons Syndrome</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 6, 1951</b> , to <b>Oct. 26, 1959</b> , that I last saw the deceased alive on <b>October 25, 1959</b> , and that death occurred at <b>1:00 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>George A. Knipp</i>		ADDRESS (Street, city or town, state) <b>4116 Edmondson Avenue</b>		DATE SIGNED <b>10/28/59</b>			
PHYSICIAN'S NAME (Type) <b>George A. Knipp, M. D.</b>		Baltimore 29, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 30, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home Catonsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 30 59</b>		24b. REGISTRAR'S SIGNATURE <i>William S. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44-38861-1000  
ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

DATE 11/11/00 BY 60322

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BIRMINGHAM 18

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Race: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Place of Birth: \_\_\_\_\_

7. Usual Residence: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Manner of Death: \_\_\_\_\_

10. Signature of Physician: \_\_\_\_\_

11. Signature of Registrar: \_\_\_\_\_

12. Date of Registration: \_\_\_\_\_

13. Place of Registration: \_\_\_\_\_

14. Signature of Informant: \_\_\_\_\_

15. Date of Information: \_\_\_\_\_

16. Place of Information: \_\_\_\_\_

17. Signature of Informant: \_\_\_\_\_

18. Date of Information: \_\_\_\_\_

19. Place of Information: \_\_\_\_\_

20. Signature of Informant: \_\_\_\_\_

21. Date of Information: \_\_\_\_\_

22. Place of Information: \_\_\_\_\_

23. Signature of Informant: \_\_\_\_\_

24. Date of Information: \_\_\_\_\_

25. Place of Information: \_\_\_\_\_

26. Signature of Informant: \_\_\_\_\_

27. Date of Information: \_\_\_\_\_

28. Place of Information: \_\_\_\_\_

29. Signature of Informant: \_\_\_\_\_

30. Date of Information: \_\_\_\_\_

31. Place of Information: \_\_\_\_\_

32. Signature of Informant: \_\_\_\_\_

33. Date of Information: \_\_\_\_\_

34. Place of Information: \_\_\_\_\_

35. Signature of Informant: \_\_\_\_\_

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55. Place of Information: \_\_\_\_\_

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61. Place of Information: \_\_\_\_\_

62. Signature of Informant: \_\_\_\_\_

63. Date of Information: \_\_\_\_\_

64. Place of Information: \_\_\_\_\_

65. Signature of Informant: \_\_\_\_\_

66. Date of Information: \_\_\_\_\_

67. Place of Information: \_\_\_\_\_

68. Signature of Informant: \_\_\_\_\_

69. Date of Information: \_\_\_\_\_

70. Place of Information: \_\_\_\_\_

71. Signature of Informant: \_\_\_\_\_

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73. Place of Information: \_\_\_\_\_

74. Signature of Informant: \_\_\_\_\_

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80. Signature of Informant: \_\_\_\_\_

81. Date of Information: \_\_\_\_\_

82. Place of Information: \_\_\_\_\_

83. Signature of Informant: \_\_\_\_\_

84. Date of Information: \_\_\_\_\_

85. Place of Information: \_\_\_\_\_

86. Signature of Informant: \_\_\_\_\_

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94. Place of Information: \_\_\_\_\_

95. Signature of Informant: \_\_\_\_\_

96. Date of Information: \_\_\_\_\_

97. Place of Information: \_\_\_\_\_

98. Signature of Informant: \_\_\_\_\_

99. Date of Information: \_\_\_\_\_

100. Place of Information: \_\_\_\_\_



## CERTIFICATE OF DEATH

10993

Reg. Dist. No.

11030

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>53</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1090 IVY HALL</u>				d. STREET ADDRESS <u>138 BLISTER ST. (20)</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>ALLEGRI</u> Last <u>NI</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-87</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEF</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRANK ALLEGRI</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS. ROSA ALLEGRI</u> (SAME AS ABOVE)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>10 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma lung</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 1, 1959</u> , to <u>Oct 29, 1959</u> , that I last saw the deceased alive on <u>Oct 29, 1959</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis Semenov</u>				ADDRESS (Street, city or town, state) <u>2108 OREMS RD</u>			
DATE SIGNED <u>10/29/59</u>							
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>				<u>BALTIMORE 20, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Connelly</u>				ADDRESS <u>Essex 21 Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10994

11031

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>713 N. Fulton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HALL</b> Middle <b>—</b> Last <b>ALLEN</b>				4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1893</b>	
9. AGE (In years not birthday) <b>65</b>		IF UNDER 1 YEAR Months <b>65</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Asphalt Road Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Amissville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry C. Allen</b>				14. MOTHER'S MAIDEN NAME <b>Mary Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 215-03-8151</b>		INFORMANT Address <b>Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>METASTATIC CARCINOMATOSIS INVOLVING PERITONEUM</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>MESENTERIC AND RETROPERITONEAL LYMPH NODES, LIVER AND ANTERIOR ABDOMINAL WALL</b> (b) <b>—</b> (c) <b>—</b>						INTERVAL BETWEEN ONSET OF DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>—</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 22, 1959</b> , to <b>October 1, 1959</b> , that I last saw the deceased <b>AM</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTO 18, MD. FT. HOWARD DIV.</b> DATE SIGNED <b>10/1/59</b>							
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, BALTO 18, MD. FT. HOWARD DIV. 10/1/59</b>					
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, BALTO 18, MD. FORT HOWARD DIV. 10/1/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Cooper</b> ADDRESS <b>512 N. Carrollton Ave., Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 6 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>	

OFFICE OF THE ATTORNEY GENERAL

1931

Memorandum

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

DATE

SUBJECT

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

10-2-31  
Charles Jones, Jr.  
Attorney General

11032

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 Croftley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>LEWIS</b> Last <b>ALLSTON</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1920</b>
9. AGE (In years last birthday) yrs. <b>39</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>District Manager</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>District Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Credit Co.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Elwood Norris Allston</b>		14. MOTHER'S MAIDEN NAME <b>Marian Fay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>137-16-8784</b>	
17. INFORMANT <b>Florence T. Allston</b>		Address <b>31 Croftley Rd., Lutherville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 11</b> , 1959, to <b>Oct 11</b> , 1959, that I last saw the deceased alive on <b>Oct 11</b> , 1959, and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George T. Gilmore</b> M.D.		ADDRESS (Street, city or town, state) <b>Lutherville, Md.</b> DATE SIGNED <b>10/13/59</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE T. GILMORE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 14, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b> ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 16 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1005

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11033

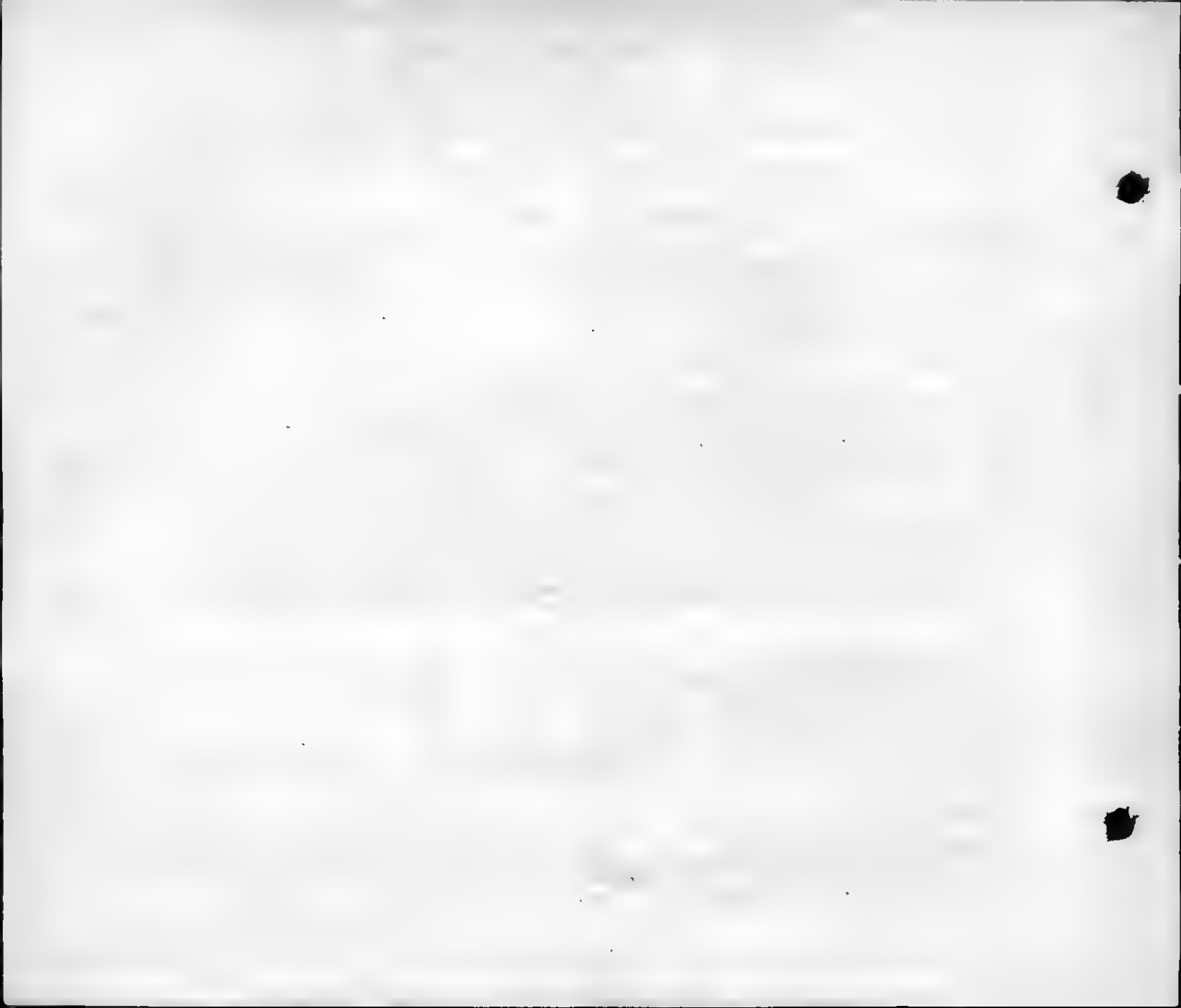
CERTIFICATE OF DEATH

10996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>md.</u> c. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSAY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Pelczar Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna Mary Anzick</u>				f. DATE OF DEATH <u>Oct 26 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 29 - 1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Vidmar</u>				14. MOTHER'S MAIDEN NAME <u>Frances Rzek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>272-01-588</u>			
17. INFORMANT <u>Anthony Anzick</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 199.2 DUE TO <u>orig. site undetermined.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 19 59</u> to <u>October 26 1959</u> , that I last saw the deceased alive on <u>10-26 19 59</u> , and that death occurred at <u>9 25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John E. Bremer</u>				ADDRESS (Street, city or town, state) <u>701 Eastern Avenue</u>			
PHYSICIAN'S NAME (Type) <u>A. Christine Brydges</u>				DATE SIGNED <u>10-26-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>German Hill Rd. Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brydges</u>				24a. REC'D BY REGISTRAR <u>1407 Eastern Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11034

## CERTIFICATE OF DEATH

10997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>506 Middle River Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis W. Asher</u>		4. DATE OF DEATH Month Day Year <u>Oct. 26, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Asher</u>		14. MOTHER'S MAIDEN NAME <u>Mary McKinley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-20-5430</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>Oct 26, 1959</u> , that I last saw the deceased alive on <u>Oct. 24, 1955</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Stern</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Oct. 27, 59.</u>	
PHYSICIAN'S NAME (Type) <u>Samuel Stern, M.D.</u>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Chase, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Stern</u> ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11035

## CERTIFICATE OF DEATH

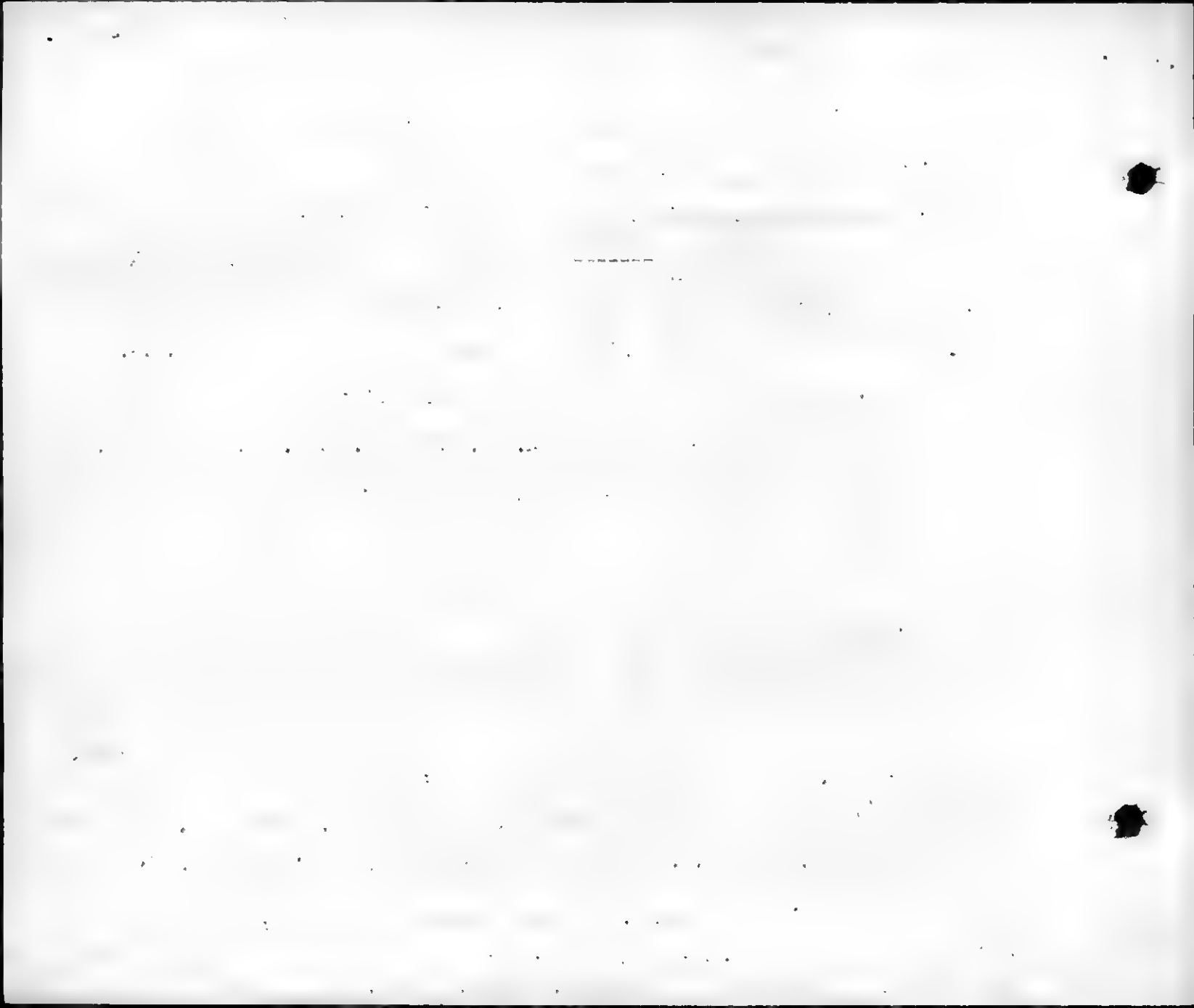
10998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>-----</b> Last <b>BARNES</b>				4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1894</b>	9. AGE (In years last birthday) <b>65</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Serana Himes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 215 18 6272</b>		INFORMANT Address <b>Clin. Rec. VAH Balto. 18, Md. Ft. Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.1 CALCIFIC AORTIC VALVULAR STENOSIS</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, GENERAL</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>October 28, 1959</b> to <b>October 31, 1959</b> and that death occurred at <b>3:18 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Clyde B. Cope</b> M.D. <b>VA Hospital, Ft. Howard, Md.</b> <b>10/31/59</b> PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE, M.D.</b> <b>VA HOSPITAL, FORT HOWARD, MD.</b> <b>10/31/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	

ARLINGTON S. PHILLIPS, 1808 N. Monroe St., Balto. 17, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

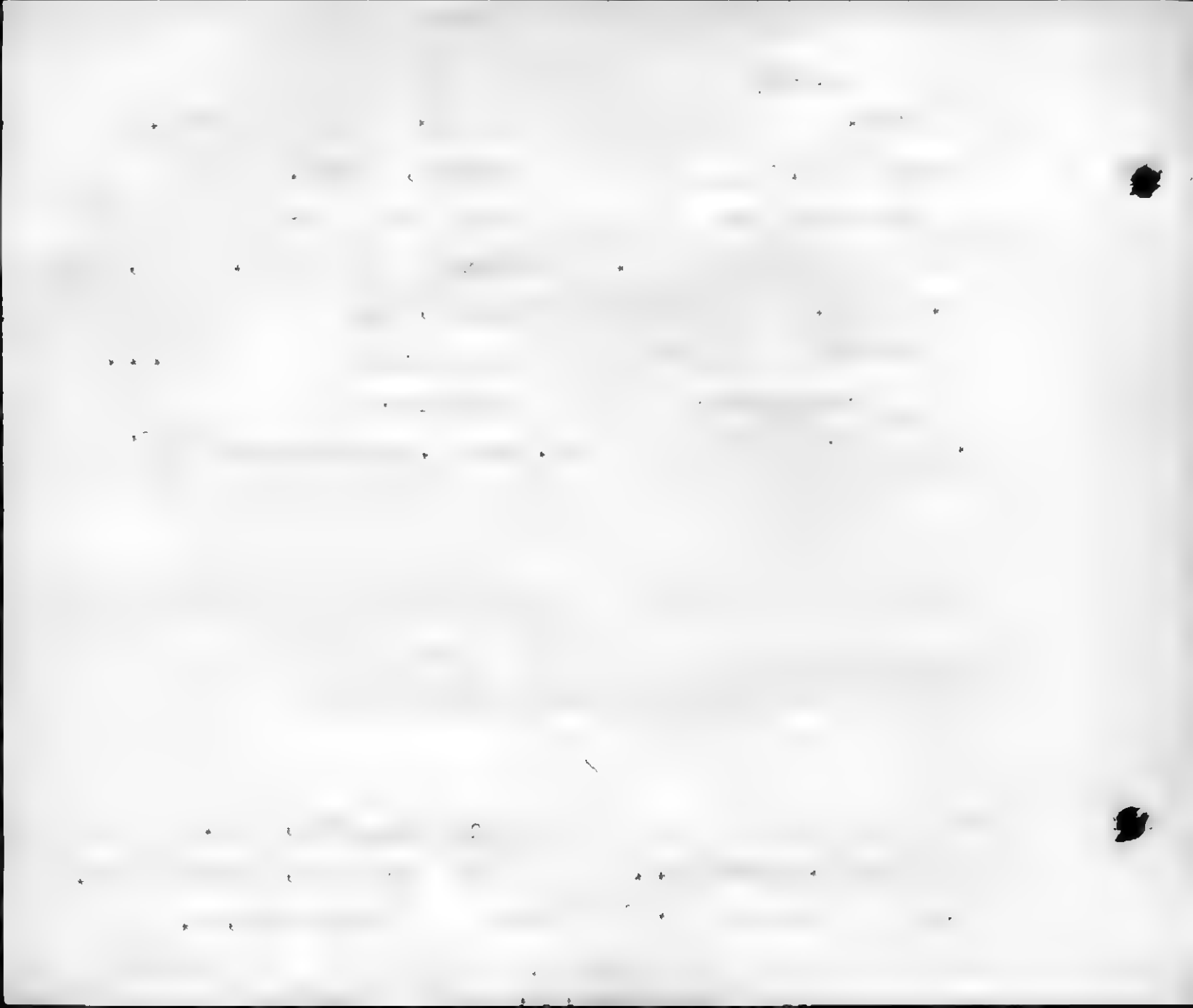
Reg. Dist. No.

10999

11036

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale, Balto., 7</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rockdale, (Balto., 7)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3632 Marriott Lane</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <b>Olive A. Barnett</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>18,</b> Year <b>1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> <b>Married</b>	8. DATE OF BIRTH <b>October 26, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months <b>3</b> Days <b>10</b> Hours <b>15</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Raver</b>		14. MOTHER'S MAIDEN NAME <b>Ida Weller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Mr. George S. Barnett</b>		Address <b>Balto. 7</b> <b>3632 Marriott Lane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1 Coronary Arteriosclerosis</b> DUE TO (b) <b>Hypertensive C.V. Disease</b> DUE TO (c) <b>Congestive Heart Failure Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>History of 3 years</b> <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/20, 1958</b> to <b>10/16, 1959</b> , that I last saw the deceased alive on <b>10/12, 1959</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8204 Liberty Road, Balto. 7</b> DATE SIGNED <b>Edwin L. Pierpont</b>			
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b> M.D.		8204 Liberty Road, (Rockdale) Balto. 7	
PHYSICIAN'S NAME (Type) <b>Edwin L. Pierpont M.D.</b>		8204 Liberty Road, (Rockdale) Balto. 7	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LORING BYERS</b>		ADDRESS <b>8728 Liberty Rd. Randallstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

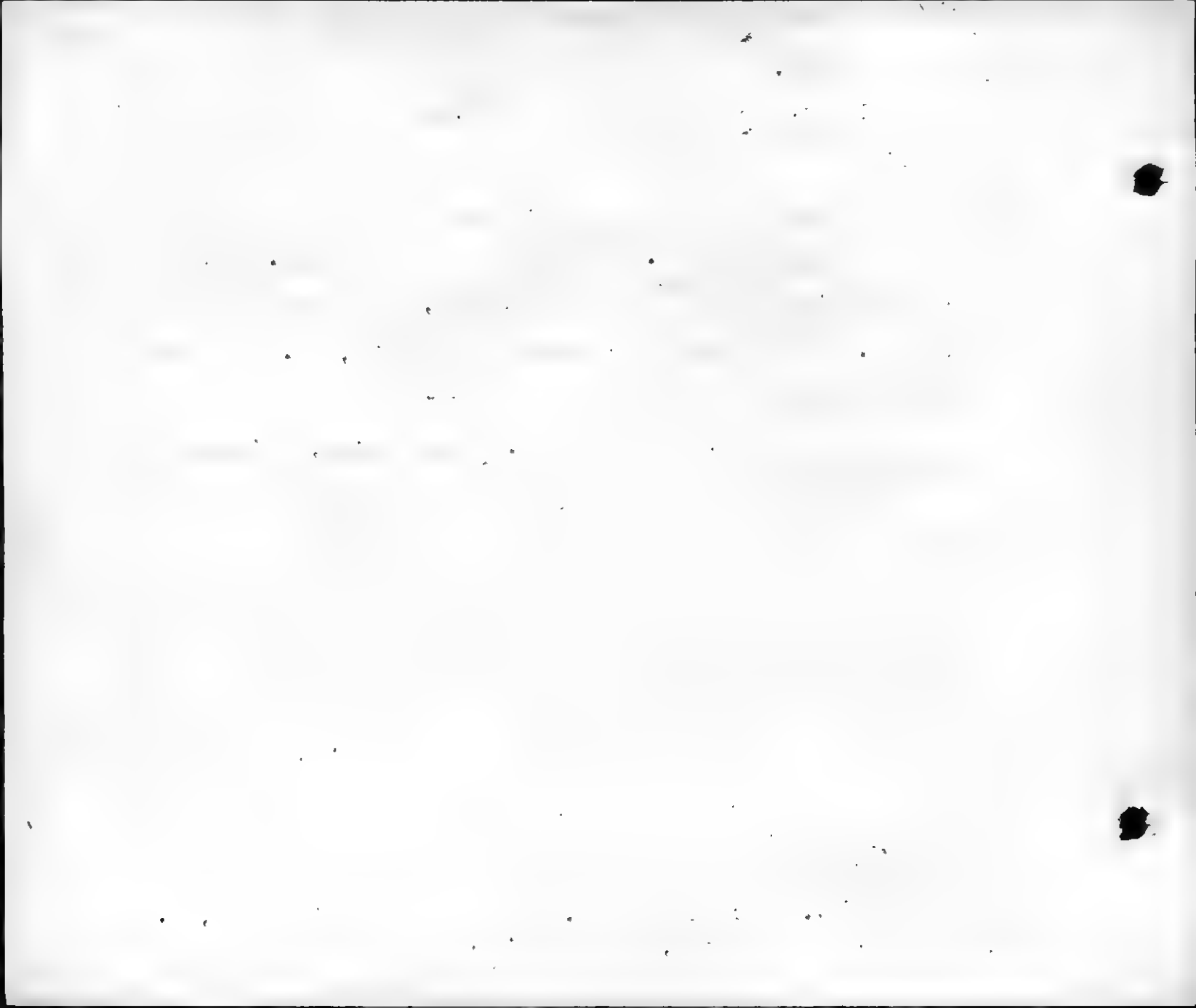
Reg. Dist. No.

11037

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>69 Merrill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>J.</b> Last <b>Bartas</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1913</b>
9. AGE (In years last birthday) yrs. <b>46</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Bartas</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>215 07 6849</b>	
INFORMANT <b>Mrs. Sarah Bartas</b>		Address <b>69 Merrill Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>metastases - generalized</b> DUE TO (c) <b>metastases - generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2-59</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-59</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-24-59</b> , 19 <b>59</b> , to <b>10-5-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-1-59</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1605 Edmondson</b> DATE SIGNED <b>10-5-59</b>			
ACTUAL SIGNATURE <b>HARRY S. GIMBEL</b>		M.D. <b>1605 Edmondson</b>	
PHYSICIAN'S NAME (Type) <b>HARRY S. GIMBEL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 6 '59</b>	
ADDRESS <b>4101 Edmondson</b>		24b. REGISTRAR'S SIGNATURE <b>Anthony A. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

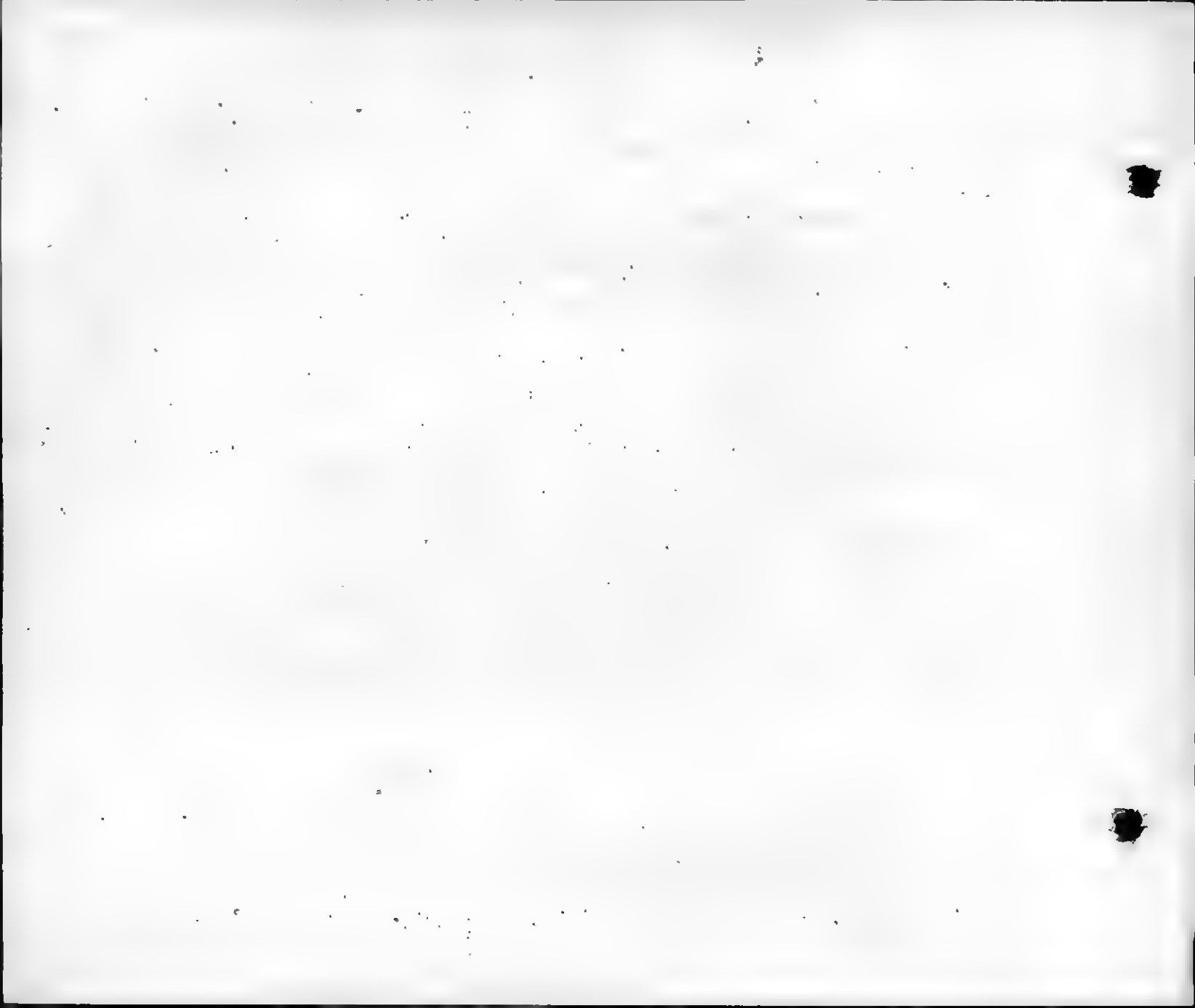
11038

## CERTIFICATE OF DEATH

Reg. Dist. No.

11001

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Conv. Home</u>				d. STREET ADDRESS <u>Greystone Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Clara N. Baumgartner</u>				4. DATE OF DEATH <u>Oct. 22</u> 19 <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29 1875</u>	9. AGE (In years day birth day) <u>84</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm.</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>H. P. Burns</u>				14. MOTHER'S MAIDEN NAME <u>S. Elizabeth Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-364042</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arterio sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>59</u> , to <u>10/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>59</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. France</u>				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. M. FRANCE</u>				DATE SIGNED <u>10/22/59</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF <u>10/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Martinelein</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kauer</u>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11002

11039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex 21</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>322 St George Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First Anastasia Middle L. Bellman Last</i>		4. DATE OF DEATH <i>Oct 3 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-3-1884</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife Retired</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George L. Choney</i>		14. MOTHER'S MAIDEN NAME <i>Anastasia Cunningham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lorena Bellman</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>G.I. hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized carcinomatosis</i> DUE TO <i>Primary site in duodenum</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>6 MON</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 2, 1953</i> to <i>10/3, 1959</i> , that I last saw the deceased alive on <i>10/1, 1959</i> , and that death occurred at <i>1:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Bellman</i>		ADDRESS (Street, city or town, state) <i>434 Eastern Ave</i>	
PHYSICIAN'S NAME (Type) <i>J. Bellman M.D.</i>		DATE SIGNED <i>10/3/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Oct 6-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James J. Burch</i>		ADDRESS <i>1405 Eastern Ave</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

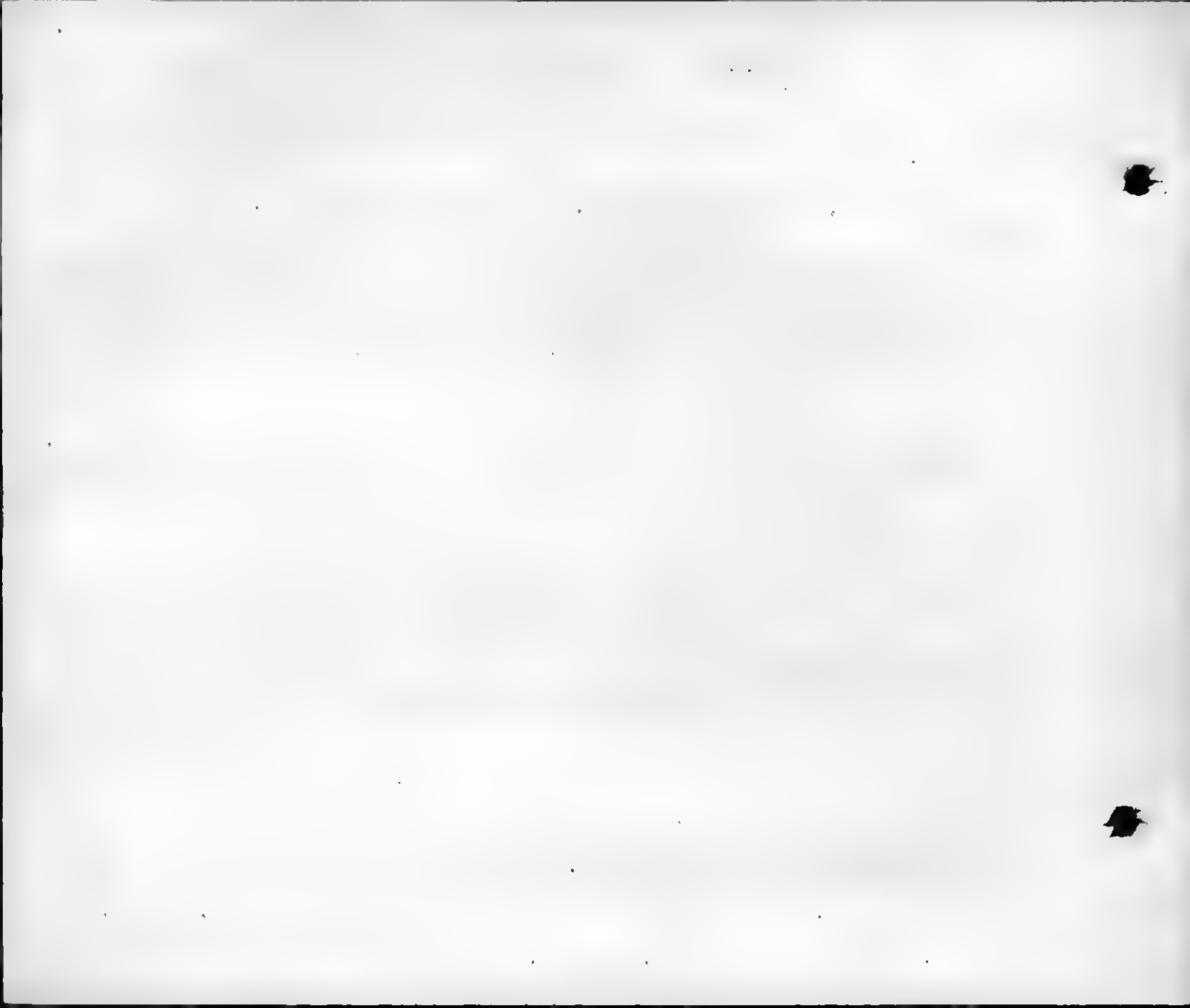
11007

## CERTIFICATE OF DEATH

Reg. Dist. No.

11003

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence, 7500 Riddle Ave.</b>		d. STREET ADDRESS <b>7500 Riddle Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Henry</b> Last <b>Boeger</b>		4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 9, 1867</b>
9. AGE (In years last birthday) <b>92 yrs</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Reed Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Richweine Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Boeger</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Elizabeth Boeger</b>		Address <b>7500 Riddle Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>March 19, 1937</b> to <b>10/18, 1959</b> , that I last saw the deceased alive on <b>10/11, 1959</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Joseph R. Liberto</b> M.D. <b>3508 Bank St.</b> <b>10/20/59</b> PREPARED BY <b>JOSEPH R. LIBERTO</b> <b>Built in 24, 24</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 21, 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>
22d. LOCATION (City, town, or county) <b>Eastern Blvd.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 22 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

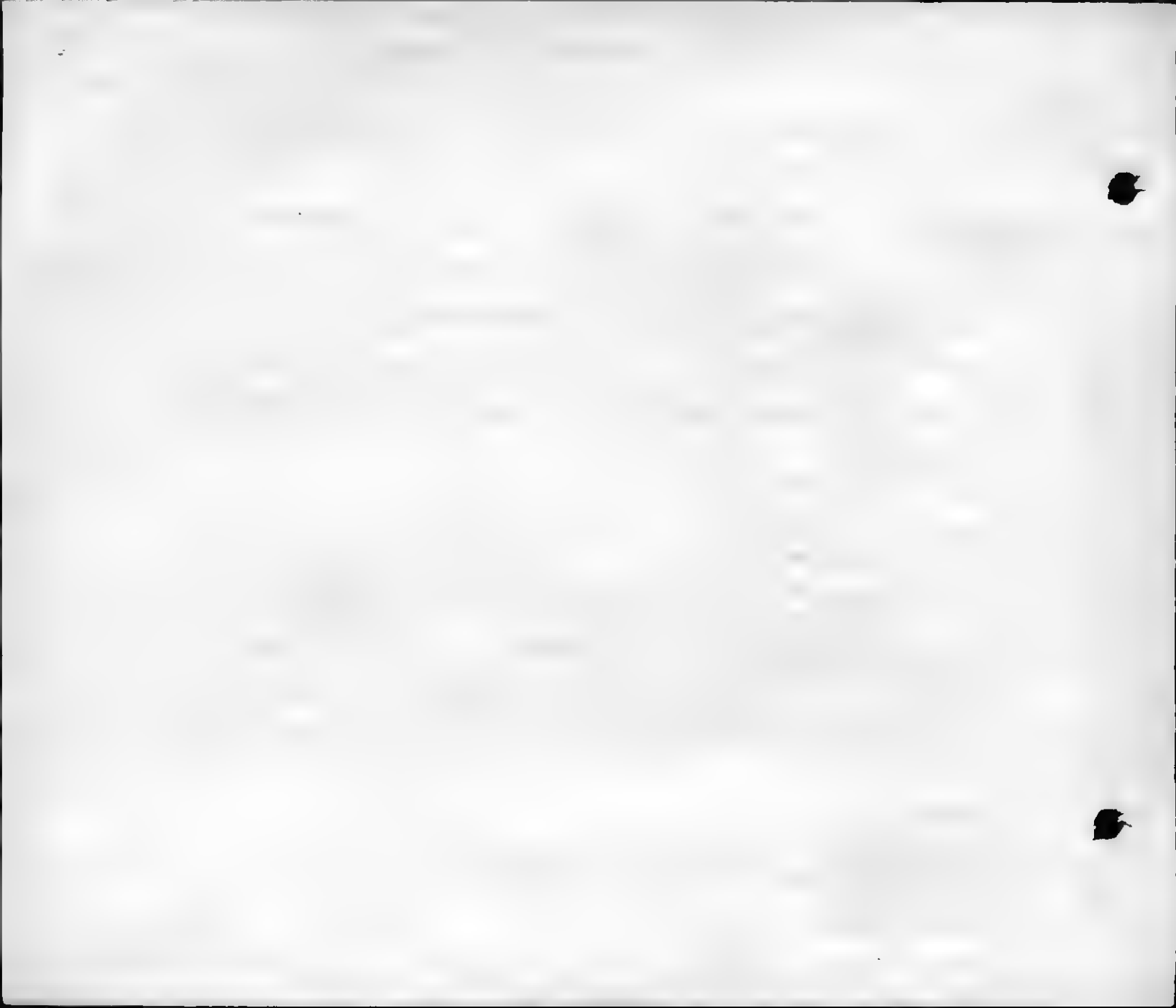
11040

## CERTIFICATE OF DEATH

11004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>md</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>512 Virginia Ave</u>		1 d STREET ADDRESS <u>512 Virginia Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Martha E. Bohneberg</u>		4. DATE OF DEATH <u>Oct 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hms</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Lawson F. Cloung</u>		14. MOTHER'S MAIDEN NAME <u>Annie La Rue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>(If yes, give war or dates of service)</u>		16 SOCIAL SECURITY NO <u>Husband</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Arteriosclerosis</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-4-1959</u> to <u>10-7-1959</u> that I last saw the deceased alive on <u>10-7-1959</u> and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>10-8-59</u>	
PHYSICIAN'S NAME (Type) <u>G. H. Silver</u>		ADDRESS (Street, city or town, state) <u>3105 N. Charlestown St. Balto. 18. Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Linwood</u>	22d. LOCATION (City, town or county) (State) <u>Balto md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Deemann (606) Hayford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Orlino R. Hanna</u>	





**X** 1  
FOR STATE  
HEALTH DEPT.

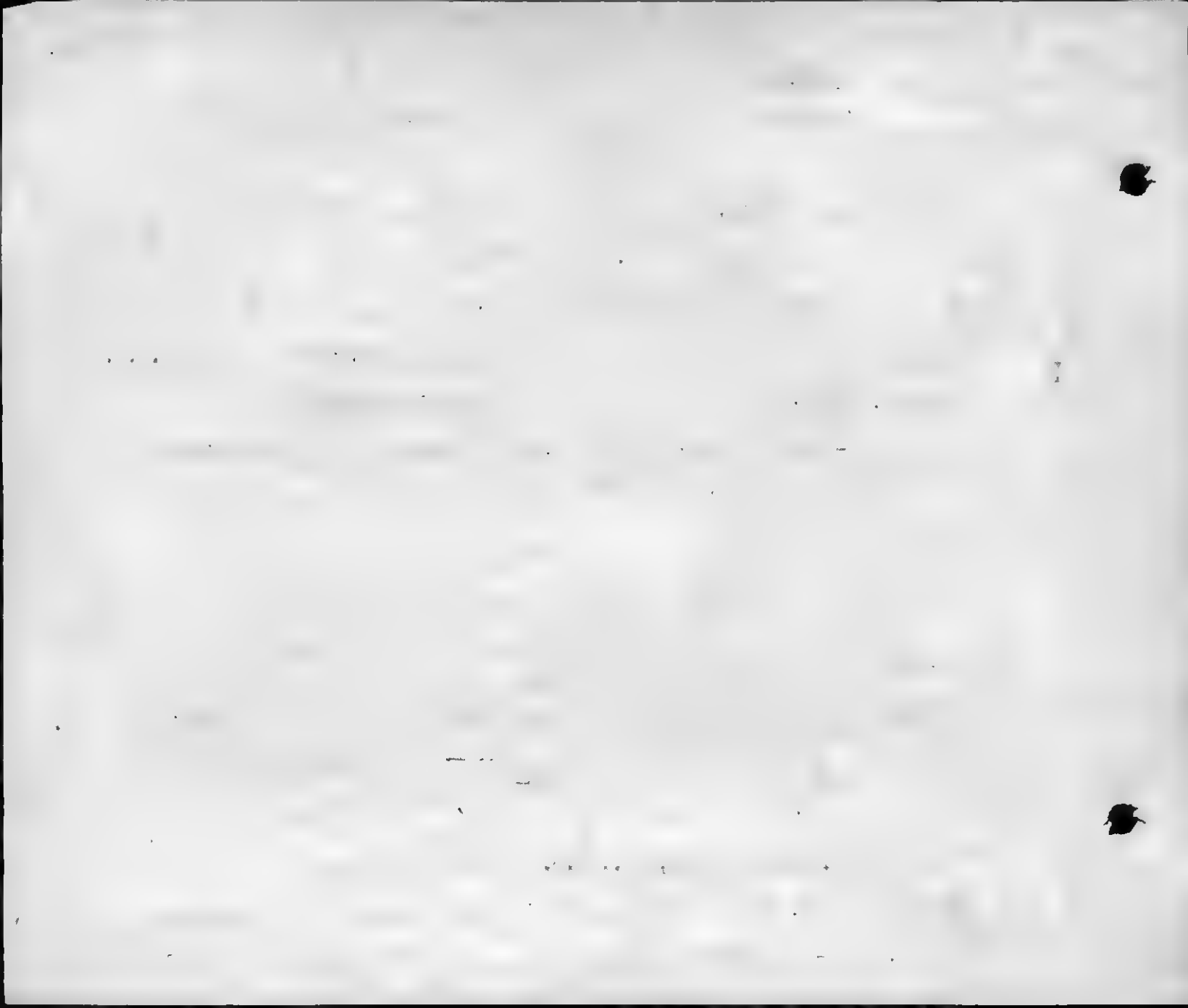
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Timonium Fair Grounds</b>				d. STREET ADDRESS <b>1232 Argyle Avenue</b>				e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>RAYMOND J. BOOKER</b>				4. DATE OF DEATH Month Day Year <b>October 6 1959</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5, 1919</b>		9. AGE (In years last birthday) <b>40</b> yrs.		F UNDER 1 YEAR F UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jockey</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph A. Booker</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Mitchell</b>				17. INFORMANT Address <b>Ameel Faulcon - 1232 Argyle Avenue</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>218-03-2874</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b>											
DUE TO (b) <b>Shot self in head</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>7:33 p.m. 10/6 1959</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fair Grounds</b>			
				20f. (City or town) <b>Baltimore</b>				(County) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>10/7/59</b>			
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		22d. LOCATION (City, town, or country) <b>Baltimore, Maryland</b>		(State)	
23. FUNERAL DIRECTOR <b>Charles R. Law</b>				ADDRESS <b>802 Madison Avenue</b>				24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	

11905



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

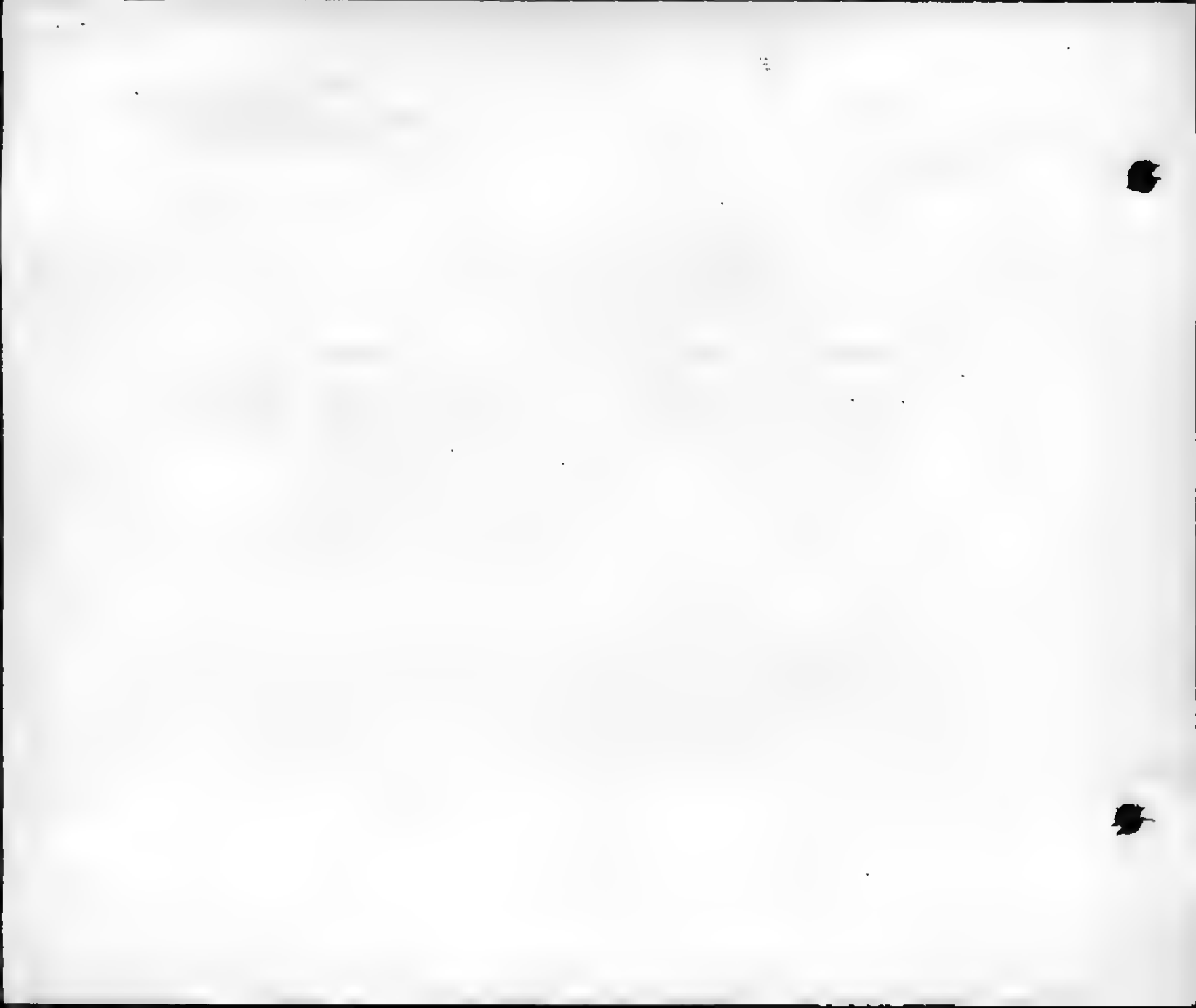
11042

## CERTIFICATE OF DEATH

11006

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <i>Md.</i> b COUNTY <i>Balto.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood Manor</i>		c LENGTH OF STAY IN lb <i>Catonsville</i>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Catonsville</i>		d STREET ADDRESS <i>13 Ingleside ave.</i> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Eva May Bowen</i> First Middle Last		4. DATE OF DEATH <i>Oct. 22 1959</i> Month Day Year	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>8/8/80</i>
9 AGE (in years last birthday) <i>79</i> yrs.		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Homemaker</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13 FATHER'S NAME <i>Chas. Lehnert</i>	
14 MOTHER'S MAIDEN NAME <i>Laura V. Powell</i>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO.		INFORMANT <i>George Bowen</i> Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Unicellular Stutter</i> DUE TO <i>Cardiac Decompensation</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>Cardiac vascular renal disease</i> (b) <i>8 months</i> (c) <i>8 years</i>		INTERVA. BETWEEN ONSET AND DEATH <i>6 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>1959</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8.18</i> , 19 <i>59</i> , to <i>10.22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10/22</i> , 19 <i>59</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George E. Urban</i> M.D.		ADDRESS (Street, city or town, state) <i>805 E. 28th St. Catonsville Md.</i> DATE SIGNED <i>10.22.59</i>	
PHYSICIAN'S NAME (Type) <i>George E. Urban</i>			
22a BURIAL, CREMATION REMOVAL (Specify)	22b DATE THEREOF <i>10/26/59</i>	22c NAME OF CEMETERY OR CREMATORY <i>Salem</i>	22d LOCATION (City, town, or county) (State) <i>Catonsville Md.</i>
23 FUNERAL DIRECTOR'S SIGNATURE <i>Mike Rabb + Son</i> ADDRESS <i>28</i>		24a REC'D BY REGISTRAR DATE <i>OCT 27 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	



11043

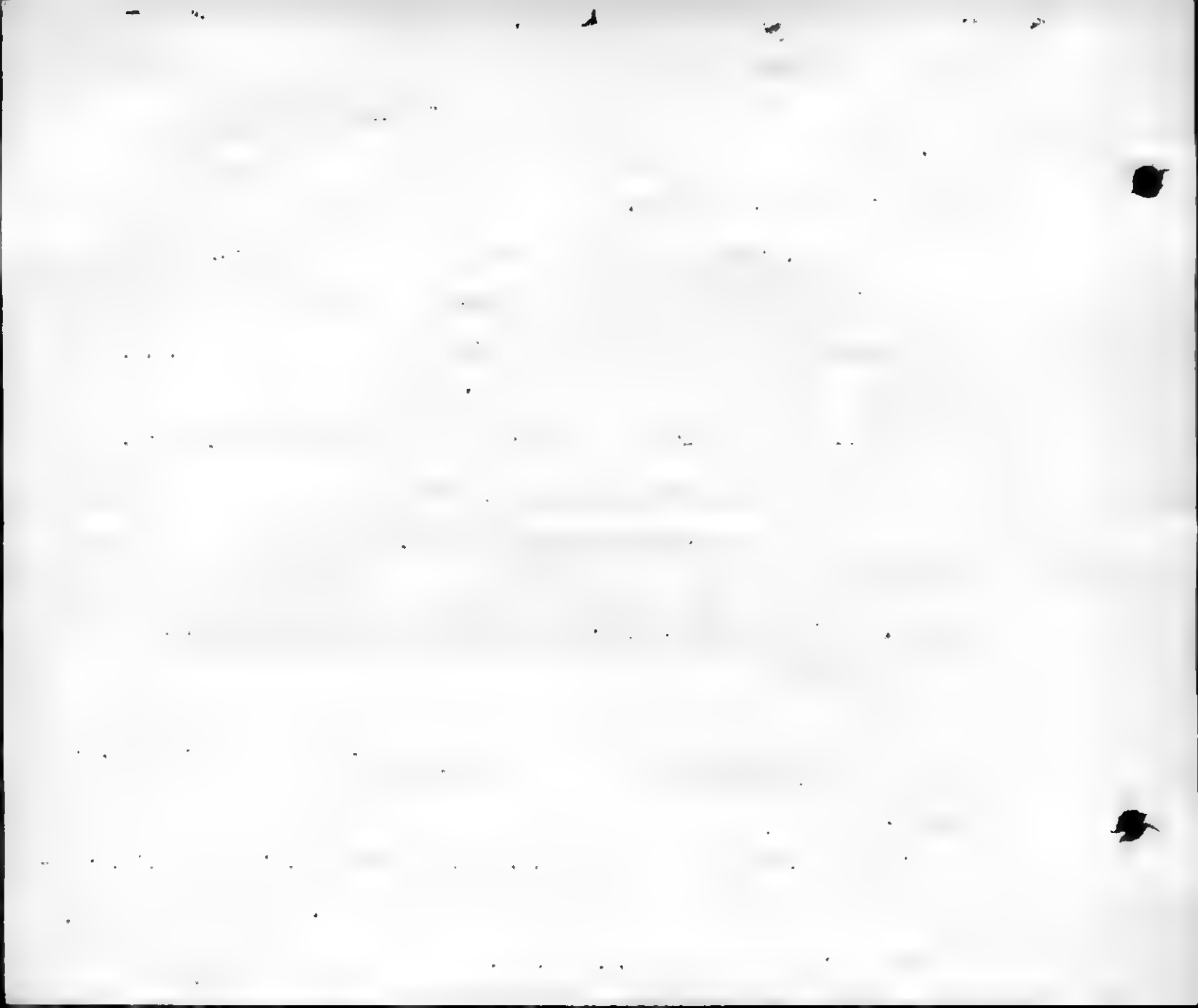
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>92 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3203 RAMONA AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>W</b> Last <b>BRAZIL</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 14 1900</b> 9. AGE (in years last birthday) <b>58</b> yrs IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN BRAZIL</b>	
14. MOTHER'S MAIDEN NAME <b>MARY BRASITIS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> If yes, give year or dates of service <b>WW-1</b>	
16. SOCIAL SECURITY NO. <b>218-22-8390</b>		INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, ACUTE</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANAPLASTIC CARCINOMA, LEFT LUNG, WITH REGIONAL METASTASIS-DURATION UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>VA</b> attended the deceased from <b>July 6, 1959</b> to <b>October 6, 1959</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John K. Ebling</b> M.D. PHYSICIAN'S NAME (Type) <b>John K. Ebling</b> M.D. <b>VAH, Baltimore, Md. Ft Howard Div. 10-7-59</b>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 10 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Old Frederick Road Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dippel Bros. Inc., 7110 Belair Rd., Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. King</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



11044

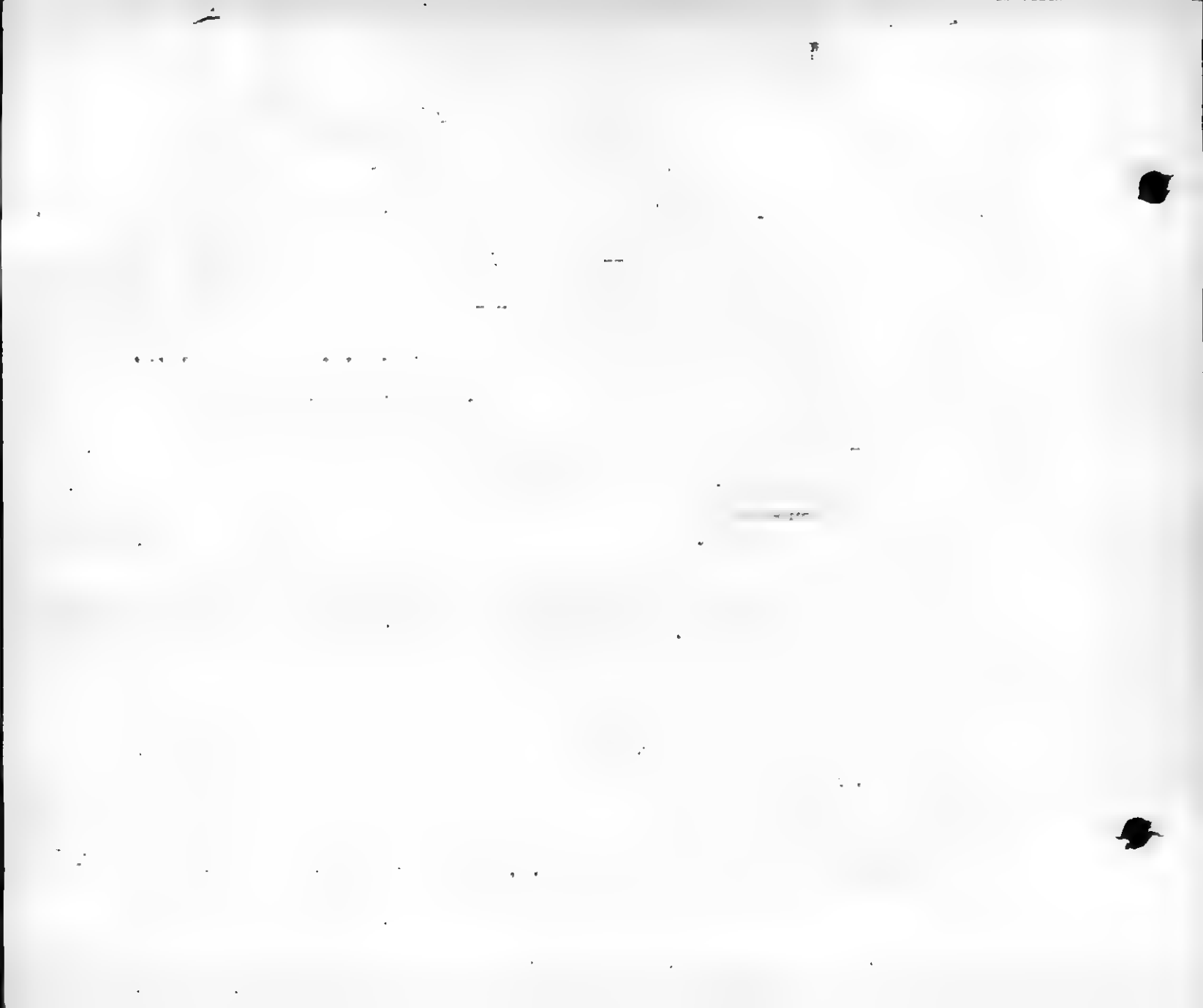
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>602 Bartlett Street</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>—</b> Last <b>Briscoe</b>		4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-3-93</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Jones</b>		14. MOTHER'S MAIDEN NAME <b>Kate Whittington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WN-1</b>	
17. INFORMANT <b>CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE ESOPHAGUS</b> <b>due to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CACHEXIA</b> (c) <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONA BILATERAL. GENERALIZED ARTERIOSCLEROSIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27</b> , 19 <b>59</b> , to <b>October 9</b> , 19 <b>59</b> , and that death occurred at <b>9:15 p.m.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>10-10-59</b>			
ACTUAL SIGNATURE <b>Harold Calvo</b>		M.D. <b>M.D. VAH Baltimore Md Ft Howard Division</b>	
PHYSICIAN'S NAME (Type) <b>Harold Calvo</b>		10-10-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips 1808 N Monroe St Balto Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kana</b>			

SHIPPED TO: HARRY S. WASHINGTON & SONS, 4990 BLK DEANE AVE, NE, WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11709

11045

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>		c. LENGTH OF STAY IN 1b <b>1yr5mth3dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			f. STREET ADDRESS <b>19 Laverne Avenue</b>		
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Eleanor</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>19 59</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1878</b>		9. AGE (in years last birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>George Davis</b>		
14. MOTHER'S MAIDEN NAME <b>Henrietta Josenham</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		
16. SOCIAL SECURITY NO <b>Unknown</b>			17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>9037</b> DUE TO <b>Acute cardiac failure</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary vascular disease</b></p> <p>(c) <b>Accident fracture</b></p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Life femur, right</b></p>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>on 5-28-59 patient became unsteady on feet and subsequently fell to floor sustaining comminuted intertrochanteric frac. of right femur</b>			
20c. TIME OF INJURY Hour <b>8:20</b> p.m. Month, Day, Year <b>5-28-59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonville 28, Maryland</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10-9-59</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon PARK Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOWARD H. HUBBARD</b>		ADDRESS <b>4107 Wilkens Ave</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>



11046

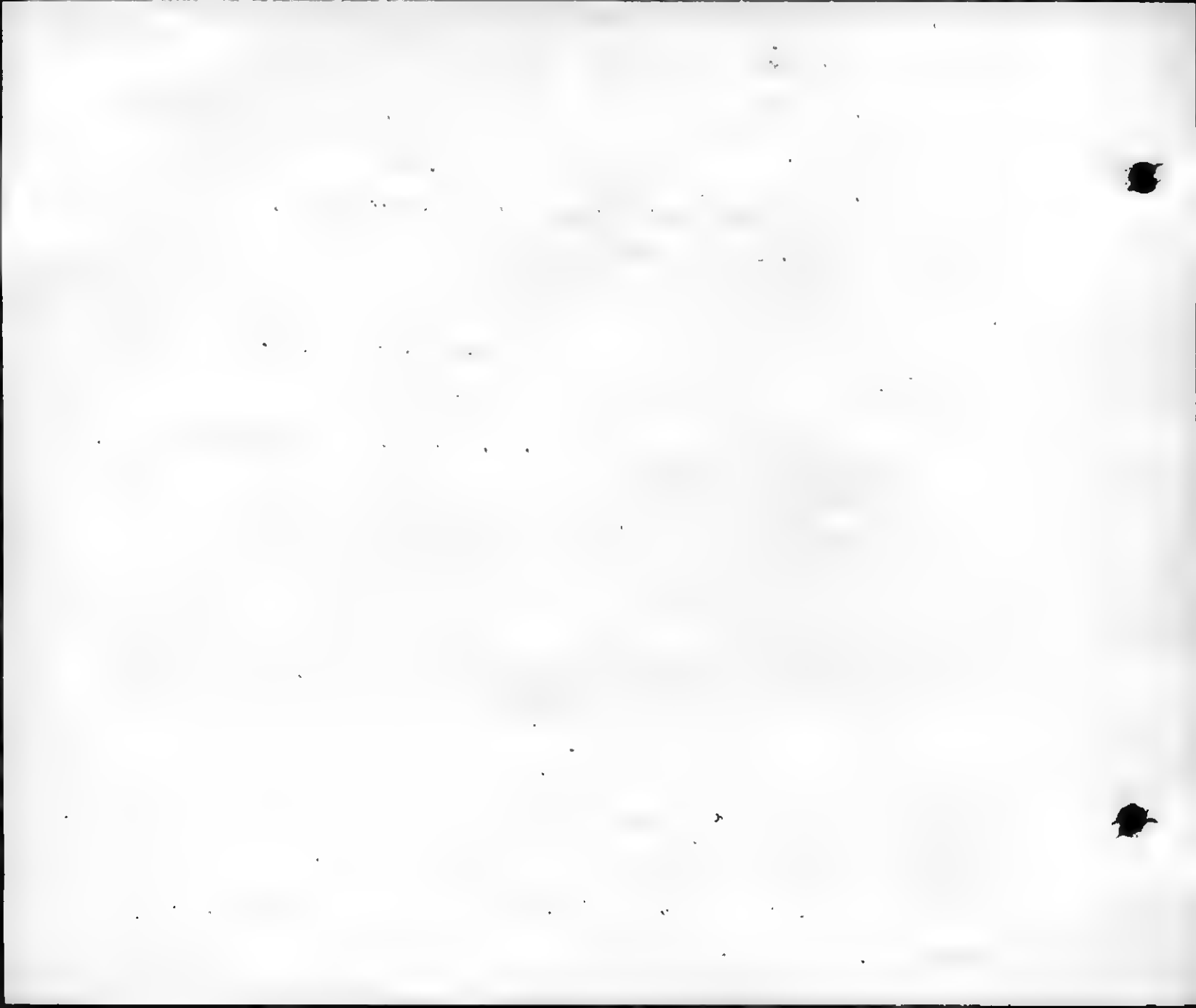
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> c. LENGTH OF STAY IN 1b <i>53</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Holly Hill Manor Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> d. STREET ADDRESS <i>1702 Aberdeen Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Katherine</i> Last <i>Caldwell</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>30</i> Year <i>1959</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 10, 1875</i>	9. AGE (In years last birthday) <i>84</i> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Hoos</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kessler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		INFORMANT Address <i>E. L. Caldwell 1702 Aberdeen Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Generalized Atherosclerosis</i> (c) <i>Fracture of Left Hip</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture of Left Hip</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Fell getting up out of Chair.</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>Aug 10 1959</i> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>Living Room</i>	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Aug 1, 1959</i> to <i>Oct. 30, 1959</i> , that I last saw the deceased alive on <i>Oct. 29</i> , 1959, and that death occurred at <i>6:50 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles E. Carr</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>6201 York Rd. 12</i>			
PHYSICIAN'S NAME (Type) <i>Charles E. Carr, Jr., M.D.</i>					
22a. BURIAL CREMATION, EXOVATION (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/2/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cemetery</i>		22d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 2 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>C. L. Kline</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11047

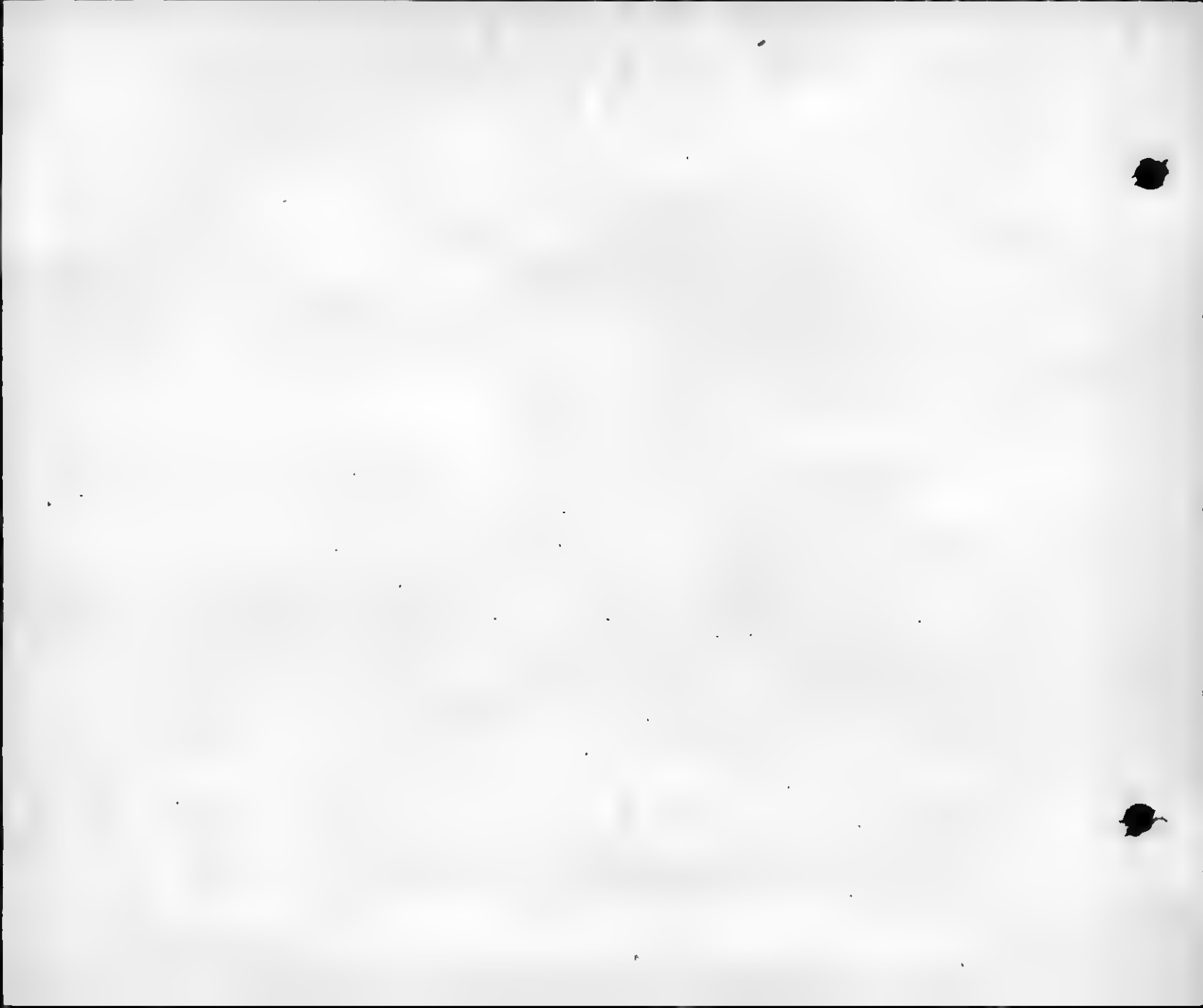
## CERTIFICATE OF DEATH

11011

Reg. Dist. No.

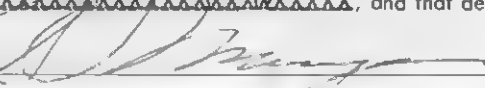

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3014 MORELAND</u>		d. STREET ADDRESS <u>13014 MORELAND AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>U. I. T. O.</u> Middle <u>A.</u> Last <u>CANOVA</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26 - 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEAM FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEATING CO</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANTHONY CANOVA</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINA POSSIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>13-12-5849</u>	
17. INFORMANT <u>JOSEPH CANOVA</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X</u> DUE TO <u>Congestive heart failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cor. Pulmonale.</u> (c) <u>Liver Fibrosis both lungs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2+ yr.</u> <u>3+ yr.</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible Hodgkins early</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 55</u> to <u>Oct 59</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>59</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Frank P. Kasik</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Harford Rd BALTO 14 MD</u>	
DATE SIGNED <u>10/10/59</u>			
PHYSICIAN'S NAME (Type) <u>F. T. KASIK JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Oct 12-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas T. Evans</u> ADDRESS <u>5802 Harford</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>

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11012

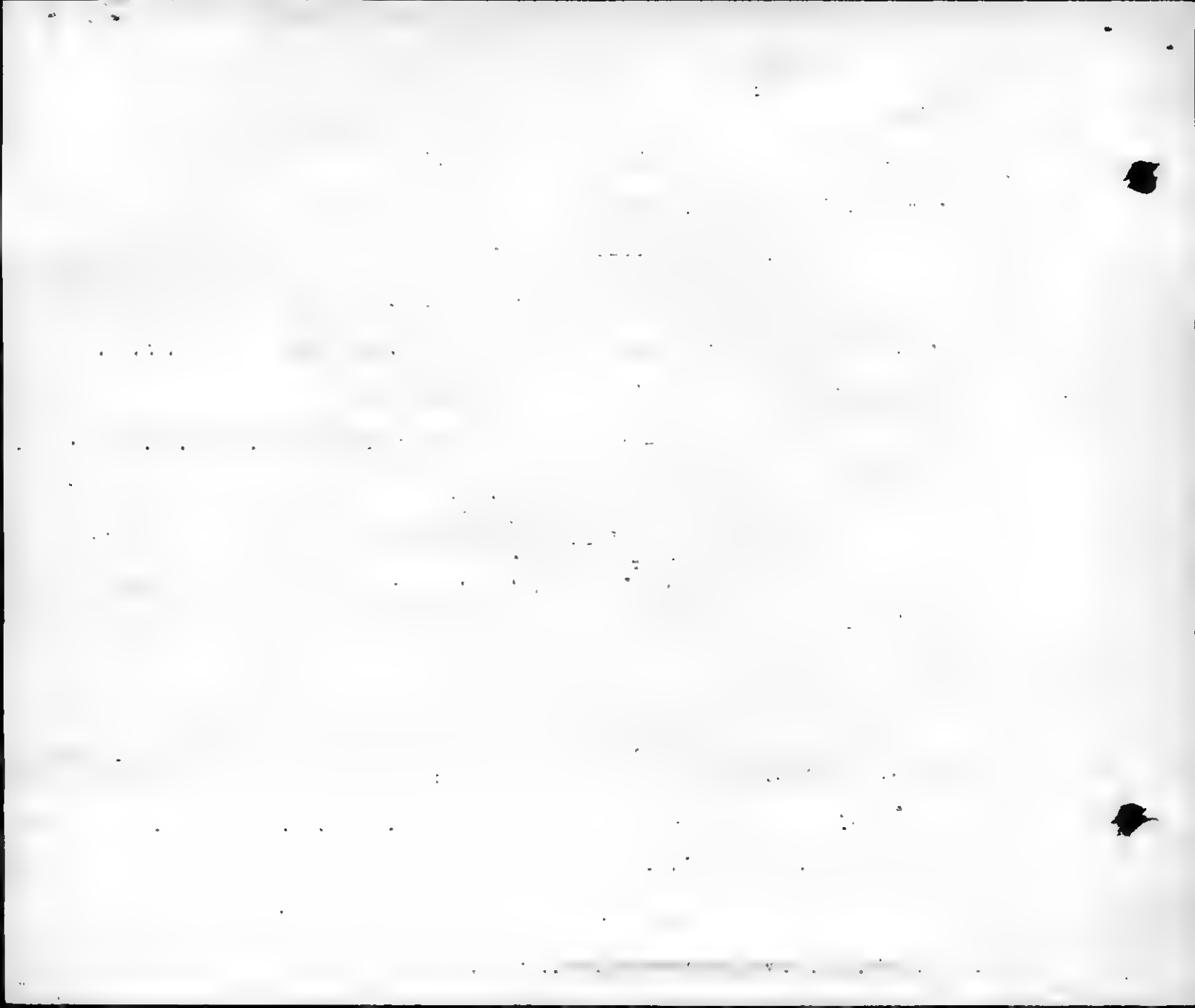
11048

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Baltimore (20)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>6 Village Green</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NAT ---- CAPRICE</b>				4. DATE OF DEATH Month Day Year <b>October 14 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 5, 1909</b>	
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tile Setter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Caprice</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Bono</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 103-07-9834</b>		INFORMANT Address <b>Clinical Records, VAH, BALTO. 18, MD. FT. HOWARD DIV.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4</b> <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO MARKED CORONARY ARTERIOSCLEROSIS</b> <b>MODERATE HYPERTENSION</b> (c) <b>HYPERTROPHY AND DILATATION OF HEART</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b> <b>5 MONTHS UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EDEMA</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 12, 1959, to October 14, 1959</b> and that death occurred at <b>6:05A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 10/14/59</b>							
ACTUAL SIGNATURE 		M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 10/14/59					
PHYSICIAN'S NAME (Type) <b>SAMUEL J. MANGUS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore (28) Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Bright, Inc. 6009 Harford Rd. S. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 15 '59</b>		24b. REGISTRAR'S SIGNATURE 	

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LSM A15 (4)  
1SM 9/58





## CERTIFICATE OF DEATH

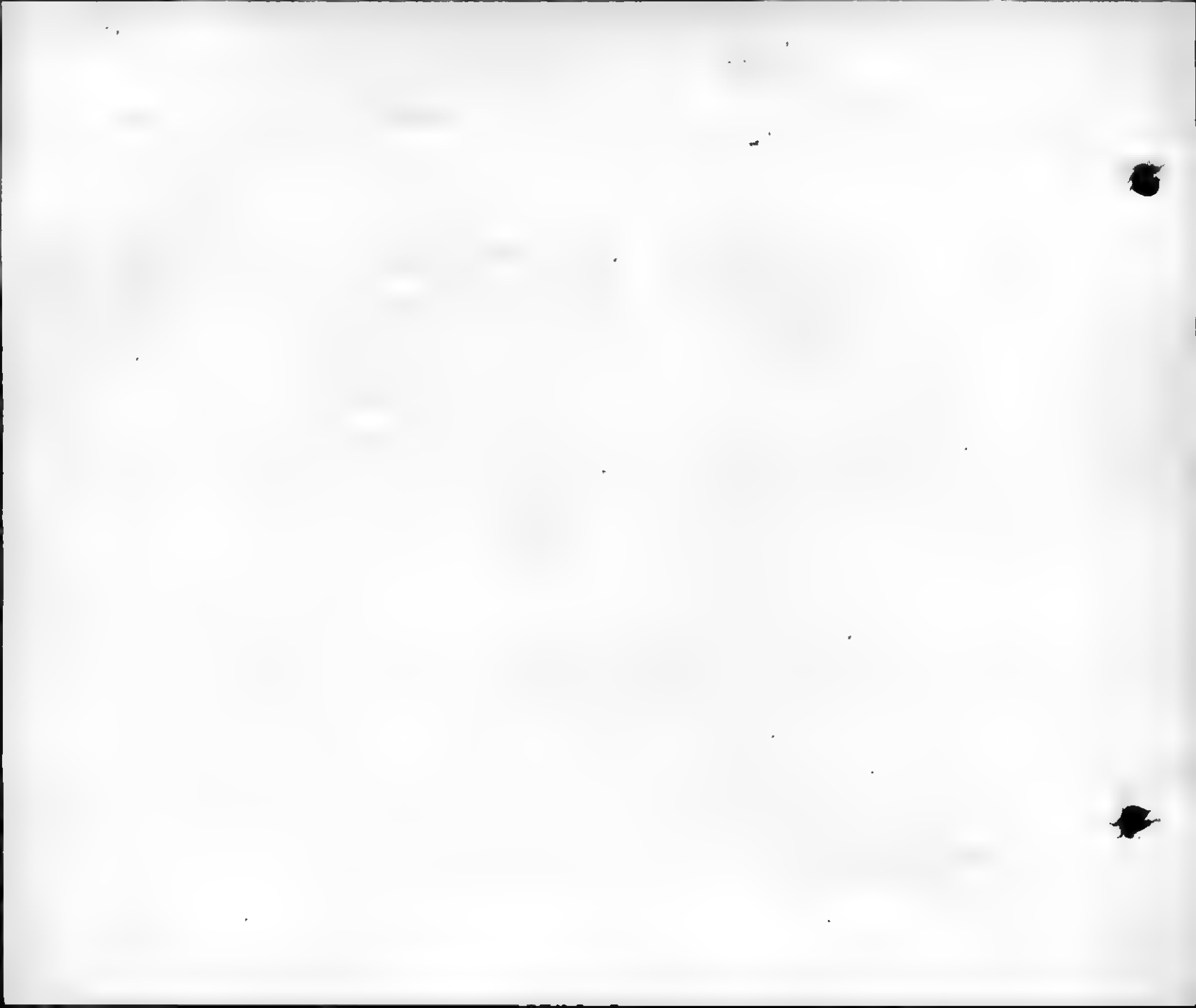
Reg. Dist. No.

11008

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>32 Broadship</b>		d. STREET ADDRESS <b>32 Broadship</b>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>R.</b> Last <b>CARDONA</b>		4. DATE OF DEATH Month <b>Oct. 7,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1877</b>
9. AGE (in years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic-- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cardona</b>		14. MOTHER'S MAIDEN NAME <b>Agatha Goetsche</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Ellda Pottleiger 32 Broadship</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>540.0</b> DUE TO (b) <b>Peptic Ulcer</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>DIABETES</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① Diabetes Mellitus - ② Asc-v Disease - ③ Nephritis</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Note</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Dundalk - 22 Md</b>	
21. I certify that I attended the deceased from <b>Oct. 1</b> , 19 <b>59</b> , to <b>Oct. 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 6</b> , 19 <b>59</b> , and that death occurred at <b>2:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M.B. Davis</b>		DATE SIGNED <b>6:00 Morning to P.M. 10/7/59</b>	
PHYSICIAN'S NAME (Type) <b>M.B. Davis M.D.</b>		<b>Dundalk - 22 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/9/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

11014

11049

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Summerfield Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT LINWOOD CARPENTER, SR.</b>				4. DATE OF DEATH Month Day Year <b>October 10 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1888 April 8, 1888</b>	9. AGE (In years lost birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>577-05-7793</b>		INFORMANT Address <b>Nettie May Carpenter - 11 Summerfield Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 YEARS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 19 59</b> to <b>OCTOBER 19 59</b> , that I last saw the deceased alive on <b>10-9-59</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2104 GWYNN OAK AVE 10-11-59</b>							
ACTUAL SIGNATURE <b>Samuel Blumenfeld</b>				PHYSICIAN'S NAME (Type) <b>SAMUEL BLUMENFELD, M.D. BALTIMORE 7, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost-4600 Liberty Hgts. Ave.</b>				24a. REC'D BY REGISTRAR <b>OCT 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>Ellsworth Armacost</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11015

Reg. Dist. No.

11050

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks, Md.</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks (rural)</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William John Carroll</u> First Middle Last <b>4. DATE OF DEATH</b> <u>OCT. 2</u> Month Day Year <u>1959</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-8-1927</u> <b>9. AGE</b> (In years last birthday) <u>32</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farm operator</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>W. Curtis Carroll</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Lupo</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W. II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-36-1232</u>		<b>17. INFORMANT</b> <u>Mary Patricia Kone Carroll</u> Address <u>above</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution - Accidental</u> <u>914.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Working in Farm Silo with a charged electric wire</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>9 10/2 1959</u> Hour <u>9</u> a.m. <u>2</u> p.m. <b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>FARM</u>		<b>20f. (City or town)</b> <u>SPARKS - BALTO.</u> (County) <u>Md.</u> (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>A. M. France</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>A. M. FRANCE</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>10/3/59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10-5-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Jessops Methodist</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Sparks Md.</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Brooks Funeral Service</u> ADDRESS <u>622 York Road</u>				<b>24a. REC'D BY REGISTRAR</b> <u>OCT 7 1959</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. H. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11051

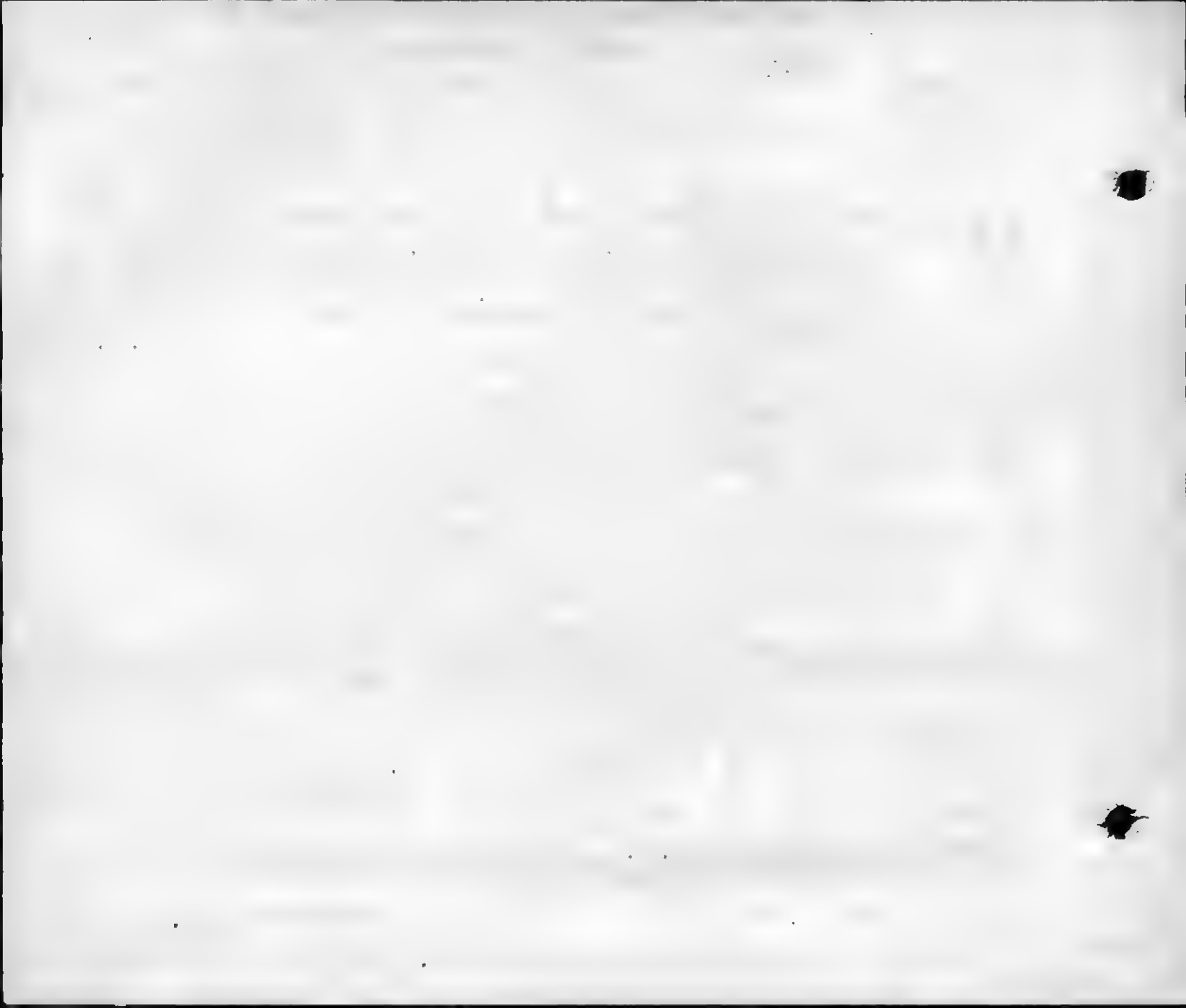
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN TB <u>4yr5mth5dys</u>				d. STREET ADDRESS <u>1802 Eutaw Place</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>W.</u> Last <u>Carter, Sr.</u>				4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1899</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auctioneer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infarctive myocardial fibrosis</u>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Arteriosclerotic cardiovascular disease with hypertension</u>							
DUE TO							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>May 10, 1955</u> , to <u>October 15, 1959</u> , that I last saw the deceased alive on <u>October 15, 1959</u> , and that death occurred at <u>9:20 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruno Radauskas</u>			ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>10-15-59</u>				
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>			<u>Catonsville 28, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Libertytown, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>WIEDEFFELD &amp; SON</u>			ADDRESS <u>GREENMOUNT AVE &amp; 22ND ST.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

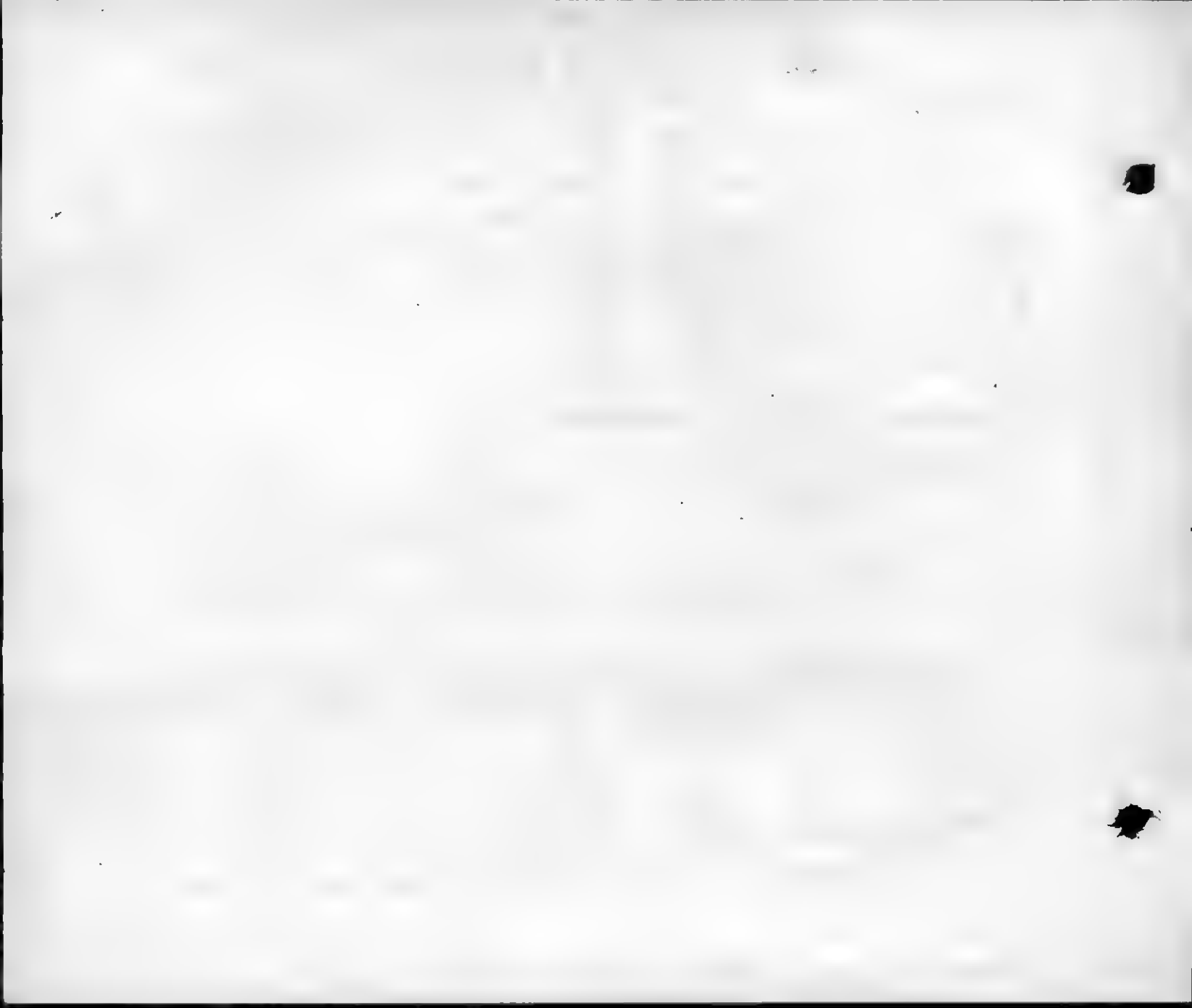
11052

## CERTIFICATE OF DEATH

Reg. Dist. No.

11017

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1307 Westellen Rd.</u>		e. STREET ADDRESS <u>1307 Westellen Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Lyle H. Cavalier</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Cavalier</u>		14. MOTHER'S MAIDEN NAME <u>Carry Cammeron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>3/17/04-3/16/07</u>		16. SOCIAL SECURITY NO. <u>216-09-5229</u>	
17. INFORMANT <u>Mrs. Virginia Moeller-1307 Westellen Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Ascending Colon, with perforation and metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholecystitis with Cholelithiasis</u> (c) <u>Acute Heart failure. Premia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 March, 1959</u> to <u>Oct 29, 1959</u> , that I last saw the deceased alive on <u>29 Oct.</u> , 1959, and that death occurred at <u>4:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Joseph E. Muse Jr. 2725 N. Charles St. (18)</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>JOSEPH E. MUSE JR 2725 N. CHARLES ST (18)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury-6411 Windsor M. Pl Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Colburn &amp; Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11018

11053

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stringtown Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>G-M</u> Last <u>CHANDLER</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germantown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. Meehan</u>		14. MOTHER'S MAIDEN NAME <u>Linda Graham</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>no.</u>	
17. INFORMANT <u>Warren J. Chandler</u>		Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas.</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 1957, to <u>Oct 17</u> , 1957, that I last saw the deceased alive on <u>Oct 15</u> , 1957, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Herbert Mueller</u> M.D.		ADDRESS (Street, city or town, state) <u>Hereford - Parkton P.O. Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR.</u>		<u>HEREFORD - PARKTON P.O. MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 20, 1959</u>	<u>Emmanuel Church, Cemetery</u>	<u>Glencoe Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Road</u>	
24a. REC'D BY REGISTRAR <u>Oct 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. K...</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11054

CERTIFICATE OF DEATH

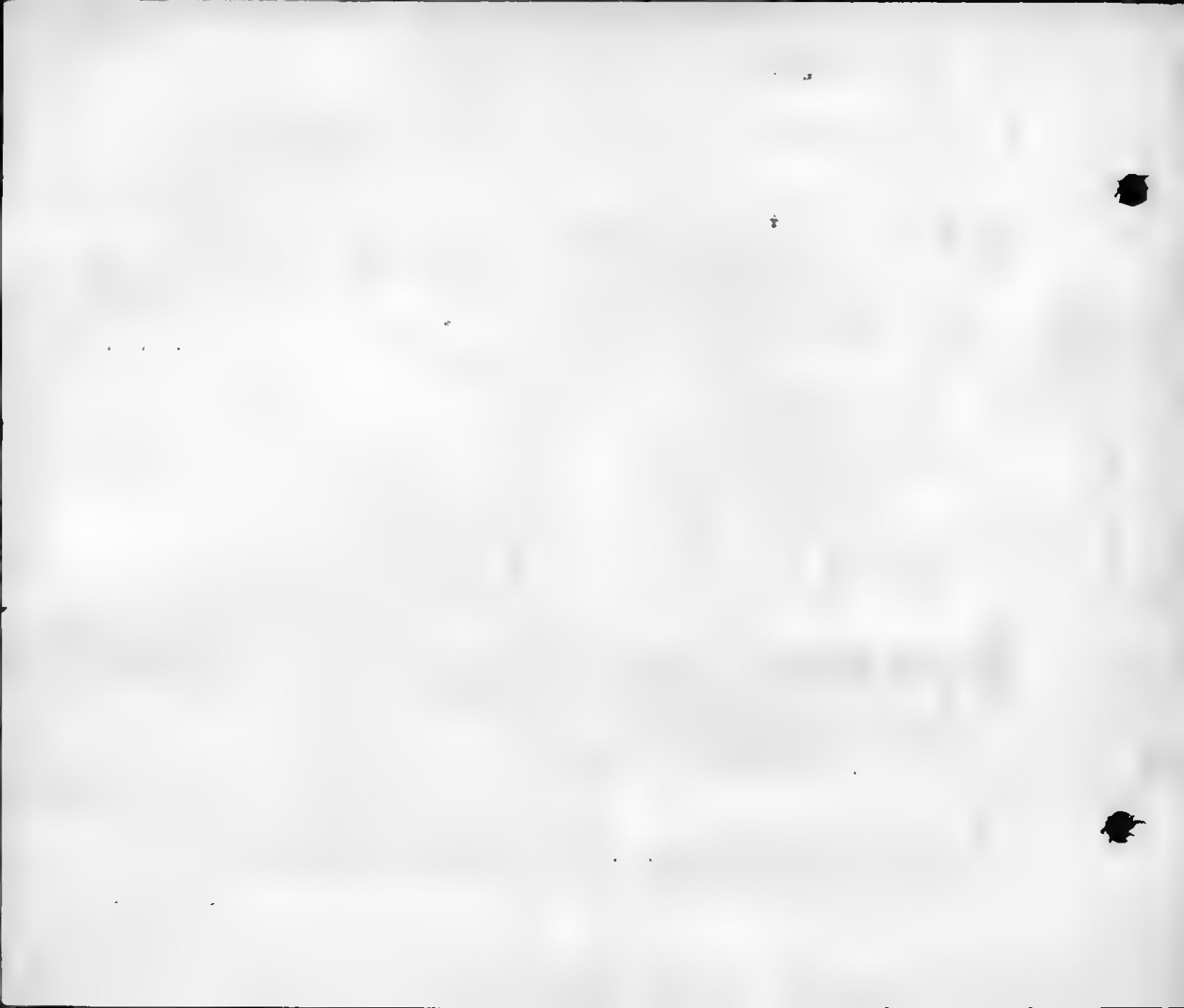
11019

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>1yr3mthldy</b>		d. STREET ADDRESS <b>Block Bridge Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Cocannon</b> Last <b>Cocannon</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1892?</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>			INTERVAL BETWEEN ONSET AND DEATH
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b>			
(c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 13, 1959</b> , to <b>Oct, 15, 1959</b> , that I last saw the deceased alive on <b>Oct. 15, 1959</b> , and that death occurred at <b>12:25aM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 10-30-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catharine</b>	22d. LOCATION (City, town, or county) (State) <b>4300 Oak Ridge</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J J Fahy</b>		24a. REC'D BY REGISTRAR <b>13/8 High</b>	24b. REGISTRAR'S SIGNATURE <b>10/2 '59</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11055

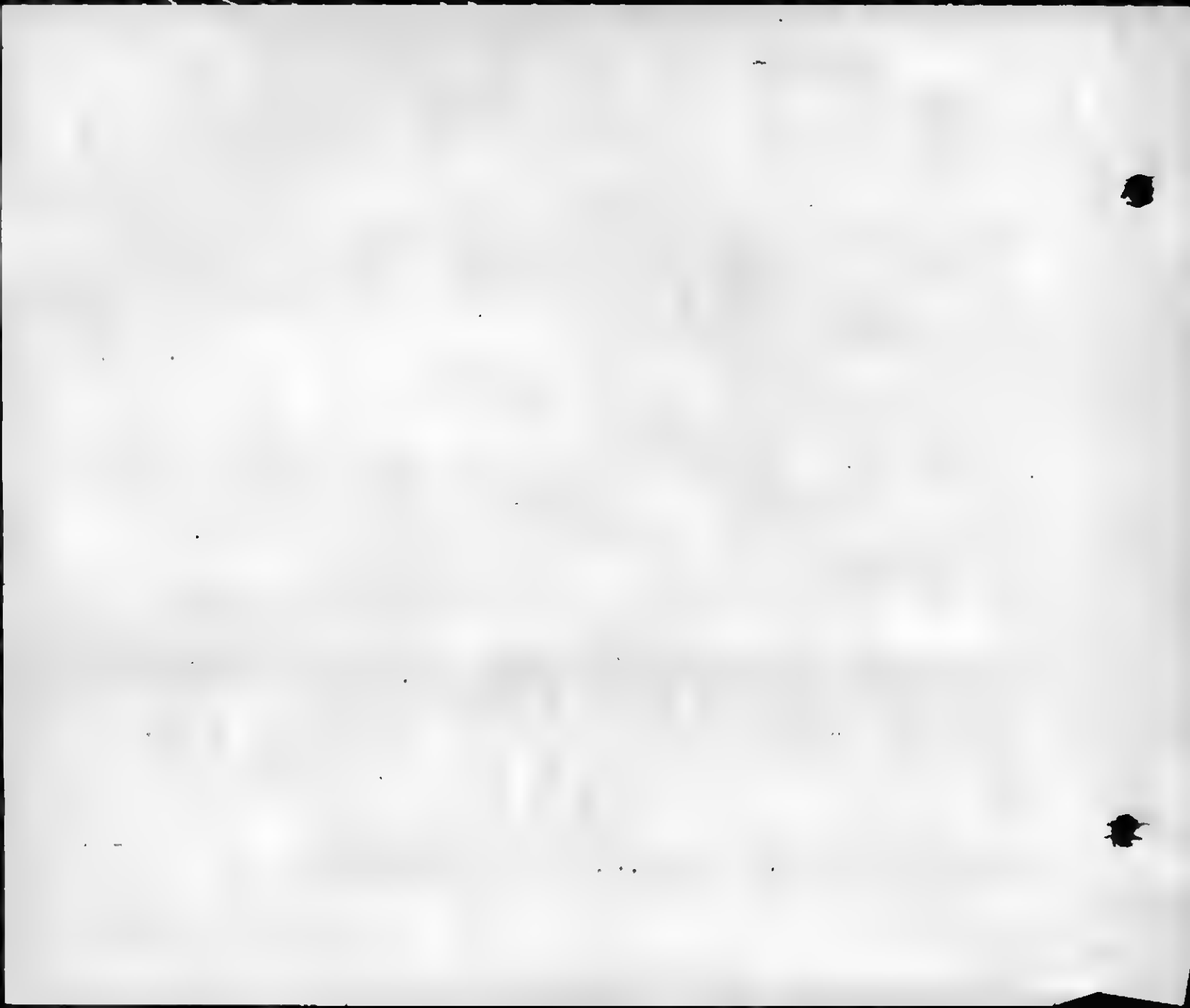
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mthldy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata, Maryland</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>LaPlata, Maryland</b>			
3. NAME OF DECEASED (Type or print) <b>Duffy</b>				4. DATE OF DEATH Month <b>10</b> / Day <b>27</b> / Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1873?</b>		9. AGE (In years last birthday) <b>86</b> yrs.	10. FUND 1 YEAR Months <b>10</b> Days <b>27</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) <b>Cardiac failure</b> b. DUE TO <b>Cardiac vascular disease</b> c. DUE TO <b>accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture left hip</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>was found with bruised, left hip.</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:30 a.m. 10-13 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 20, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE: <b>Geo. M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10-28-59</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family Plot</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Moody Funeral Home</b>				ADDRESS <b>Mt. Airy, N.C.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneave</b>			

THIS MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please advise the certifying authority, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





11056

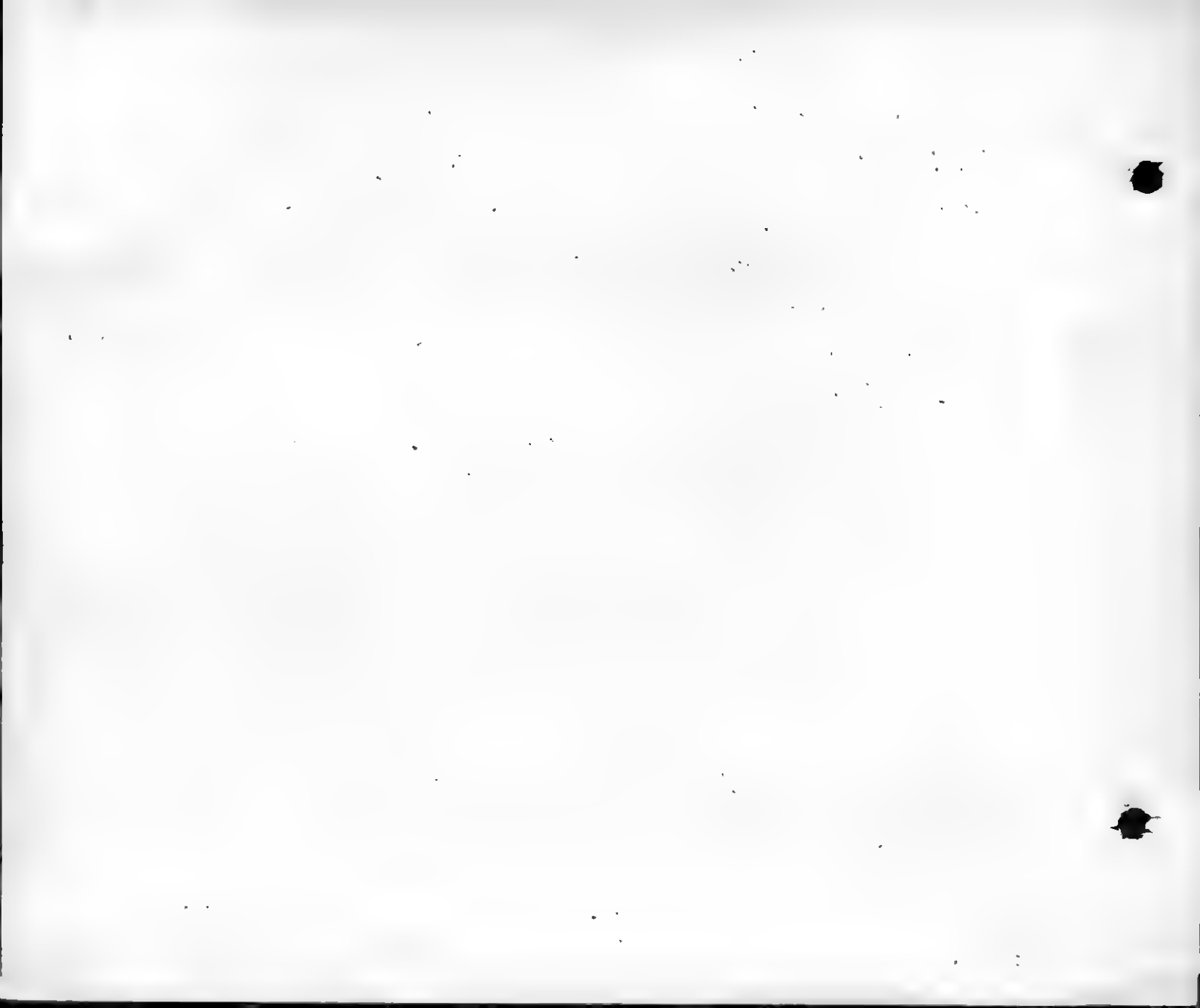
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Cohen</u> Middle Last		4. DATE OF DEATH Month <u>10</u> - Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years <u>87</u> yrs. Months Days Hours Min.)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Esiah</u>		14. MOTHER'S MAIDEN NAME <u>Souza</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Harry Bass - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy, left hemiplegia</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 29, 1959</u> to <u>Oct 3, 1959</u> , that I last saw the deceased alive on <u>Sept 10, 1959</u> , and that death occurred at <u>220A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Krause</u> M.D. <u>118 Chase St</u>		DATE SIGNED <u>10/4/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Leonard - 2100 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11057

## CERTIFICATE OF DEATH

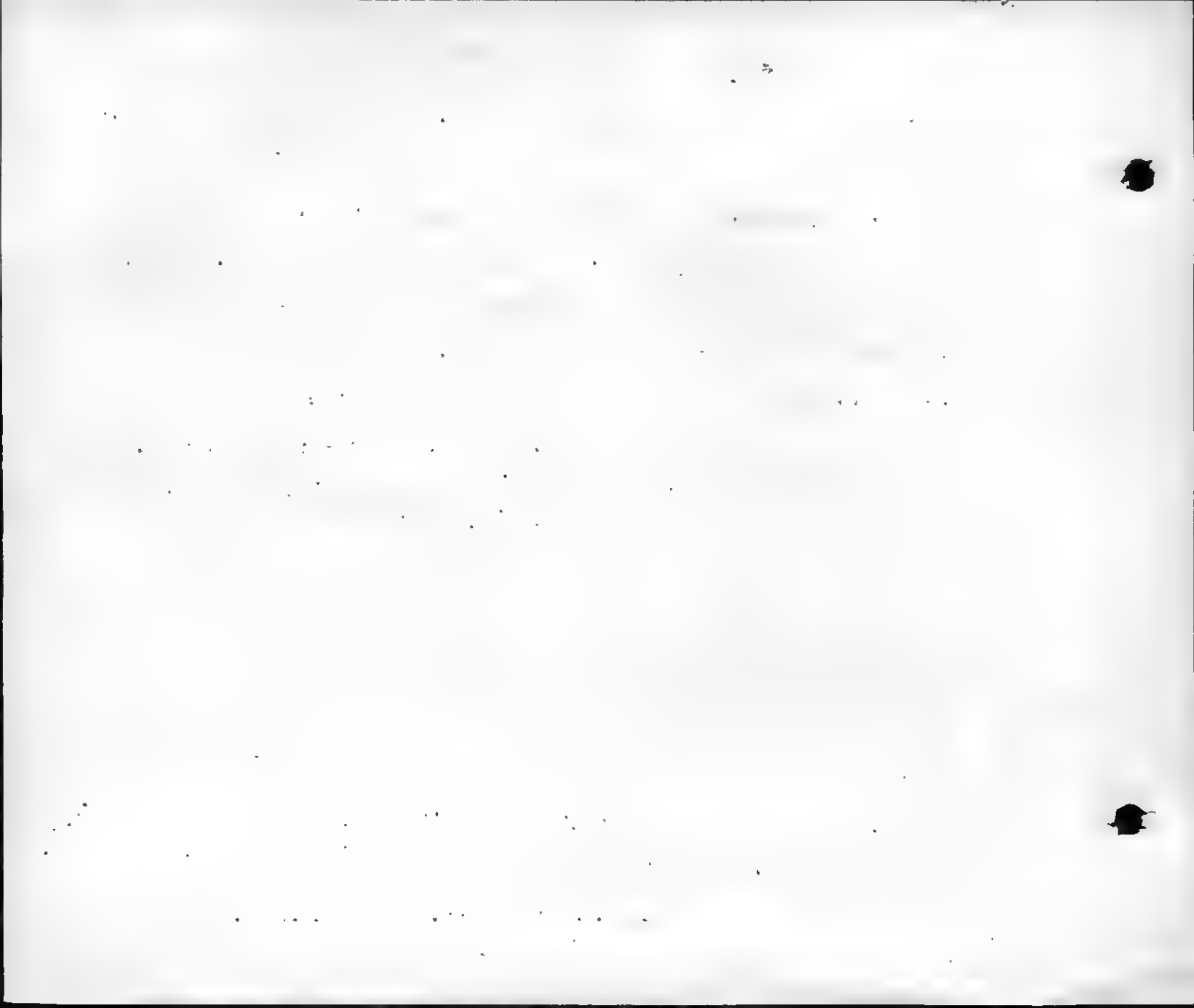
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Woodmoor Zone 7</b>		d. STREET ADDRESS <b>3615 Keston Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Home</b> <b>1002 N. Rolling Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET V. CONNER</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>Oct. 13, 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1898</b>		9. AGE (In years lost birthday) <b>61</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Dominic M. Larkin</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Boyle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <b>Mr. Homer G. Conner - 3615 Keston Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Squamous cell Carcinoma of the bladder</b> <b>1810</b> DUE TO <b>with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 Sept. 1959</b> to <b>13 Oct. 1959</b> , that I last saw the deceased alive on <b>12 Oct. 1959</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Emil H. Henning Jr.</b> M.D. <b>601 Winans Way</b> <b>14 Oct 59</b> PHYSICIAN'S NAME (Type) <b>EMIL H HENNING JR MD</b> <b>601 WINANS WAY (29)</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>1617 17th St - Baltimore</b>		24a. REC'D BY REGISTRAR DATE <b>Oct 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

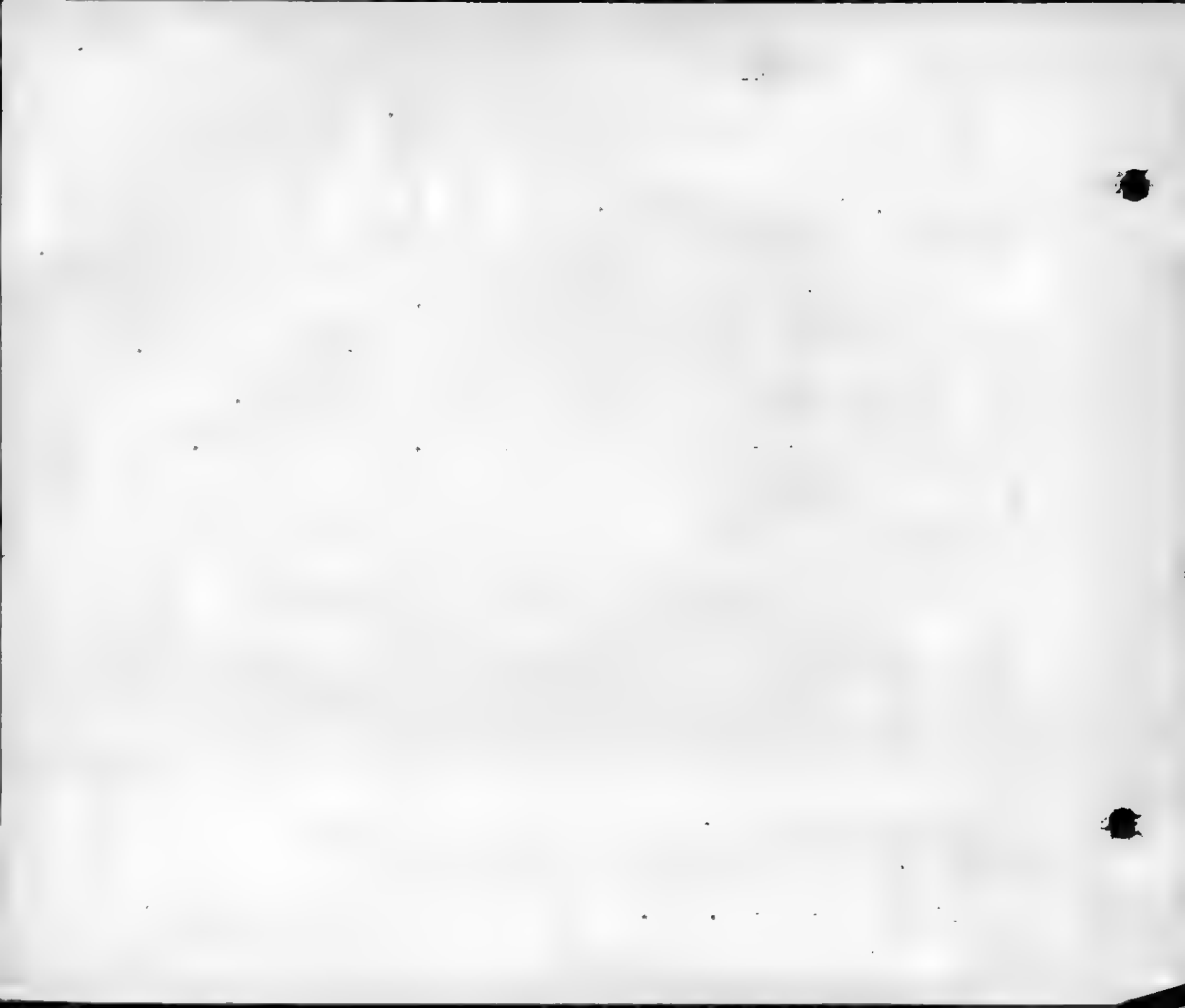
11023

11058

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write PLURAL and give nearest town) <b>Eastwood</b>		c. LENGTH OF STAY IN 1b <b>Eastwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>407 S. Old North Point Rd.</b>		e. STREET ADDRESS <b>407 S. Old North Pt. Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN FRANCIS COXON.</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>59.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b>	11. IF UNDER 24 HRS Hours <b>19</b> Min <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Box Maker</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Coxon</b>		14. MOTHER'S MAIDEN NAME <b>Jane Hallworth.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Charles F. Coxon</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 Min</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack C Collins</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-2 -59.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>5712 O'Donnell St. BALTO, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Gailis</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
ADDRESS <b>901 S CONKLING ST. BALTO, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Gailis</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

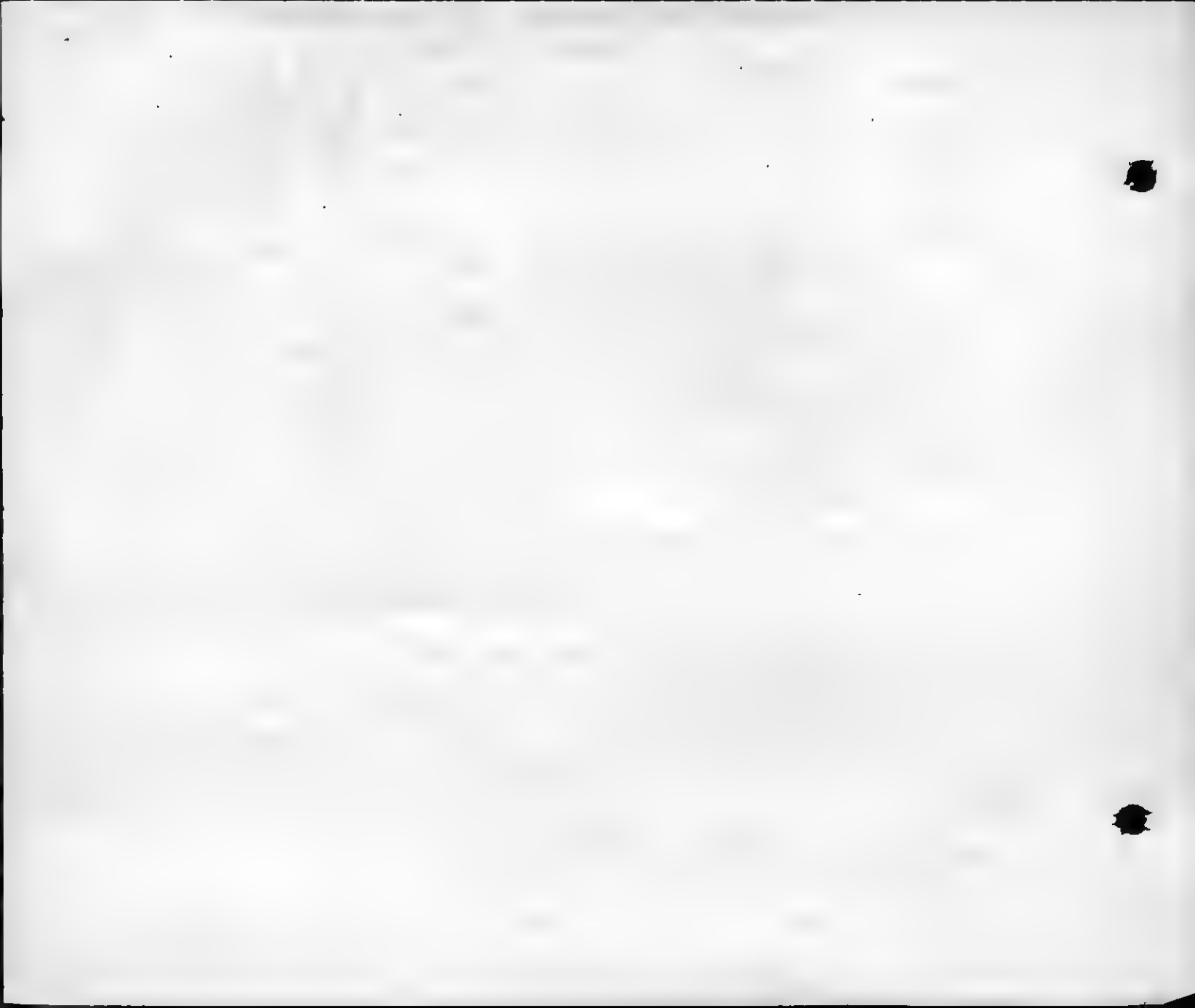
Items 7,8,9 FilmG251 10-30-59 et

## CERTIFICATE OF DEATH

11024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pepper Hill Rd. Perry Hall, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pepper Hill Rd.</u>		d. STREET ADDRESS <u>Pepper Hill Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Ashford</u> Last <u>Curwood</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Exeter-England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Curwood</u>		14. MOTHER'S MAIDEN NAME <u>Jane Kent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bladwen Curwood</u>		Address <u>Pepper Hill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO (b) <u>Arteriosclerosis (advanced)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Oct.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 21</u> , 19 <u>59</u> , and that death occurred at <u>4:20</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>Oct. 22, 1959</u> ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Kingsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sharon Fum Home</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Christina S. Kiana</u>





may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

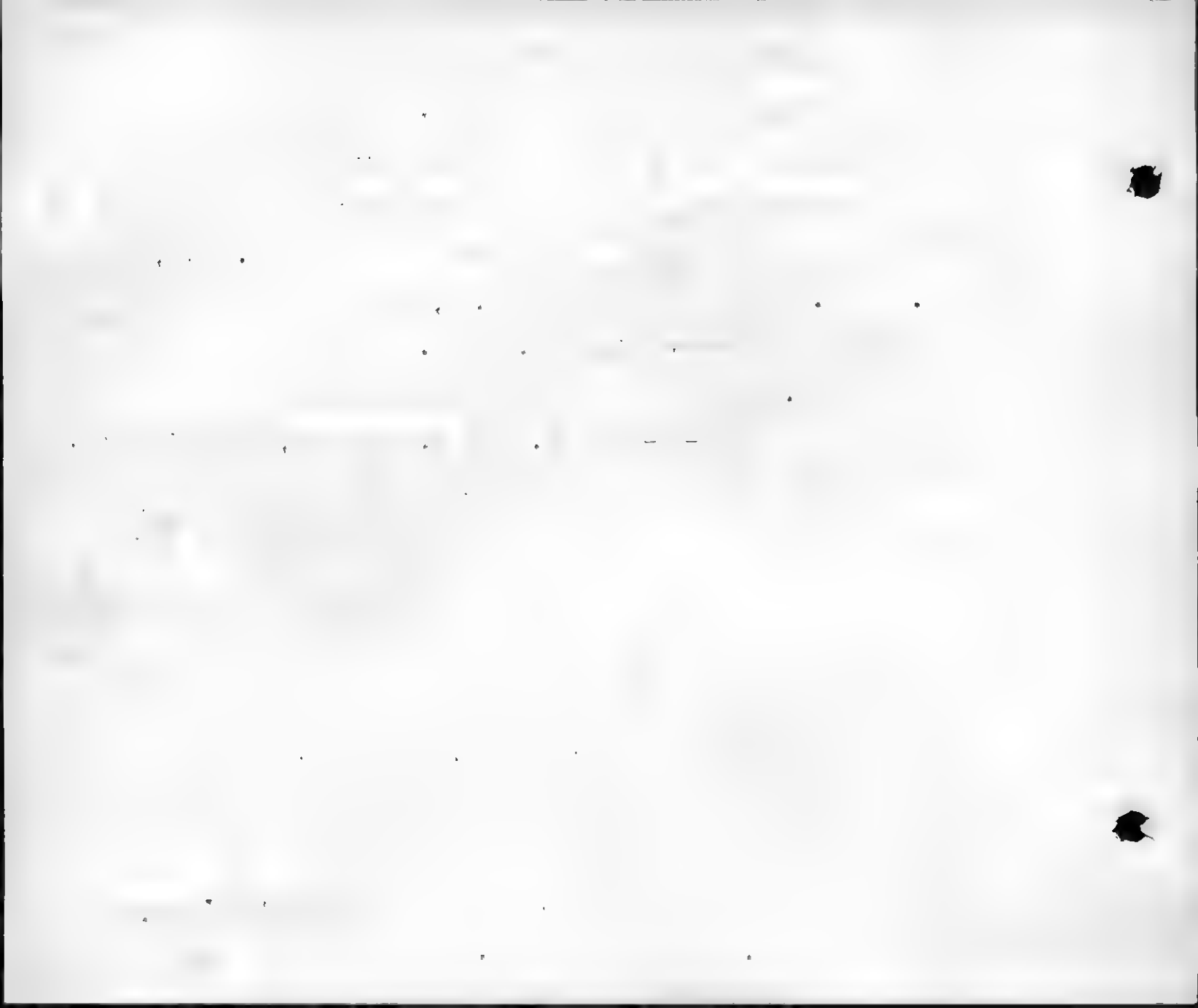
11020

CERTIFICATE OF DEATH

Reg. Dist. No.

11025

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdown</b>		c. LENGTH OF STAY IN 1b <b>13 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2109 Smith Ave</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdown</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mae</b> Last <b>Davenport</b>		4 DATE OF DEATH Month <b>Oct.</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1924</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mason Dixon Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>Pa.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John M. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>205-12-2937</b>	
17. INFORMANT <b>Mr. David B. Davenport</b>		Address <b>2109 Smith Ave.</b>	
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF CAECUM</b> <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>ABOUT 4 MOS.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>8/15/1959</b> to <b>10/25/1959</b> that I last saw the deceased alive on <b>10/25/1959</b> and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William T. Muse M.D.</b>		ADDRESS (Street, city or town, state) <b>2436 WASH. BLVD.</b>	
DATE SIGNED <b>10/25/59</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM T. MUSE M.D.</b>		<b>Balt 30 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>Oct. 27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pomfret Manor Cemetery</b>	
22d. LOCATION (City, town or county) <b>Sunbury, Pa.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11026

11060

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4407 Glenmore Ave.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> d. STREET ADDRESS <u>4407 Glenmore Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Harry C. Davis</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Oct. 14, 1959</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 28, 1869</u>
<b>9. AGE</b> (In years last birthday) <u>90 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min  <b>11. IF UNDER 24 HRS.</b> Months Days Hours Min  	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>P. R. R.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William H. Davis</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine V. Raley</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>717-07-7632</u>	
<b>17. INFORMANT</b> Address <u>Mrs. Bernard O'Brien 4407 Glenmore Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cardiac Decomposition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> (c) <u>Arteriosclerosis generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u> 			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) 			
<b>20c. TIME OF INJURY</b> Month. Day. Year Hour o. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 		<b>20f. (City or town)</b> (County) (State) 	
<b>21. I certify that I attended the deceased from</b> <u>9/18</u> <b>19</b> <u>59</u> <b>to</b> <u>10/14</u> <b>19</b> <u>59</u> <b>that I last saw the deceased alive on</b> <u>9/17</u> <b>19</b> <u>59</u> <b>and that death occurred at</b> <u>2:25</u> <b>P.M.</b> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>Louis D. Klimes</u> <b>M.D.</b> <u>2623 E. Monument St</u> <b>DATE SIGNED</b> <u>10/14/59</u> <b>PHYSICIAN'S NAME (Type)</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Oct. 17, 1959</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lanahan Funeral Home</u>		<b>ADDRESS</b> <u>7401 Belair Rd</u>	
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>OCT 19 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11061

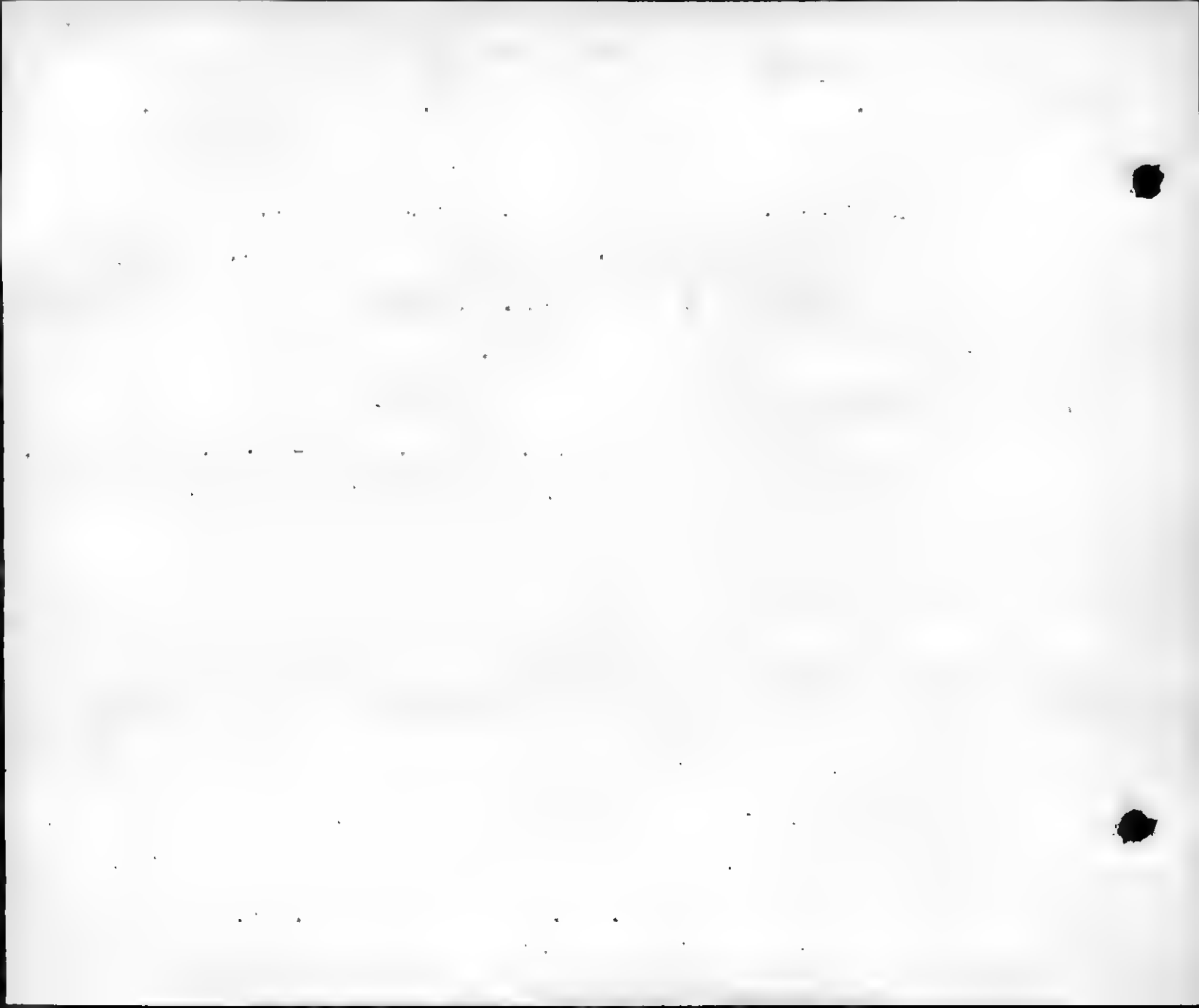
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Professional House 133 Slade Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>S.</b> Last <b>DIXON</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>6,</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs	10. IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>-</b>		13. FATHER'S NAME <b>Frank Spurry</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Sylvester</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>Mrs. Joseph C. Miceli - 10908 Reisterstown Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8 Carcinoma of colon with metastases 1 yr.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>6 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2 Oct</b> , 19 <b>59</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>808 Reisterstown Rd</b> DATE SIGNED <b>7 Oct 59</b> ACTUAL SIGNATURE <b>Paul H Royce</b> PHYSICIAN'S NAME (Type) <b>Paul H Royce</b> <b>Pikesville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/9/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lickner &amp; Sons - Balto</b> <b>17 Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kenna</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



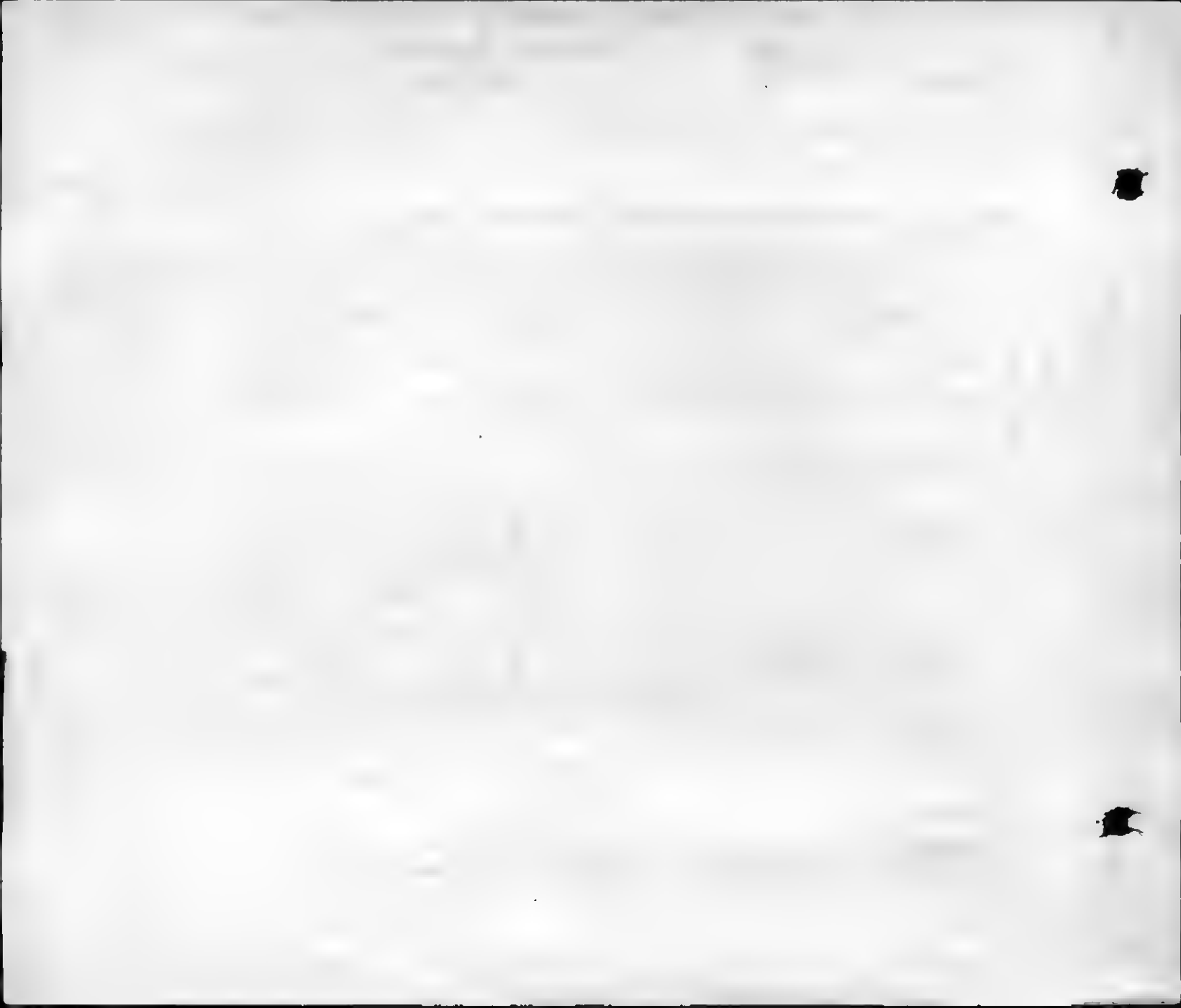
11062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOUSE IN THE PINES</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Richard S. Dodson</b>				4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 3, 1863</b>		9. AGE (In years last birthday) <b>96</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SENATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STATE GOV'T.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>RICHARD S. DODSON II</b>				14. MOTHER'S MAIDEN NAME <b>MARIA F. PFELTZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>—</b>		17. INFORMANT <b>MRS. MARIE D. MULLIN</b> Address <b>233 E. UNIV. PKWY. Bldg</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 da.</b> <b>10 yr.?</b> <b>10 yr.?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>7-19-1957</b> to <b>10-17-1957</b> , that I last saw the deceased alive on <b>10-17-1957</b> , and that death occurred on <b>4:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Ave.</b> DATE SIGNED <b>10/17/57</b>							
ACTUAL SIGNATURE <b>Wilmer K. Gallager</b>				M.D. <b>Baltimore-28-Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallager</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. JENKINS &amp; SONS CO. 4905 YORK ROAD</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 21 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

11063

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b> Md. </b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>RURAL</b> and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>732 Beechfield Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Barbara S. <del>DOERING</del> Doering</b>		4. DATE OF DEATH <b>Oct. 3, 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1874</b>
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR: Months <b> </b> Days <b> </b> Hours <b> </b> Min <b> </b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown Lorenc Limmer</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Sabina Bartholmew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b> </b>	
17. INFORMANT <b>Louis Doering</b>		Address <b>732 Beechfield Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO (b) <b> </b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b> </b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b> </b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b> </b> Day <b> </b> Year <b>19</b> Hour a. m. <b> </b> p. m. <b> </b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1956</b> to <b>Oct 3, 1959</b> , that I last saw the deceased alive on <b>Oct 2, 1959</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl Pass M.D.</b>		ADDRESS (Street, city or town, state) <b>4001 Wilkens Ave Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Earl Pass, M. D.</b>		DATE SIGNED <b>10-6-59</b>	
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10'6'59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue</b>	
24a. REC'D BY REGISTRAR <b>Oct 7 59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	

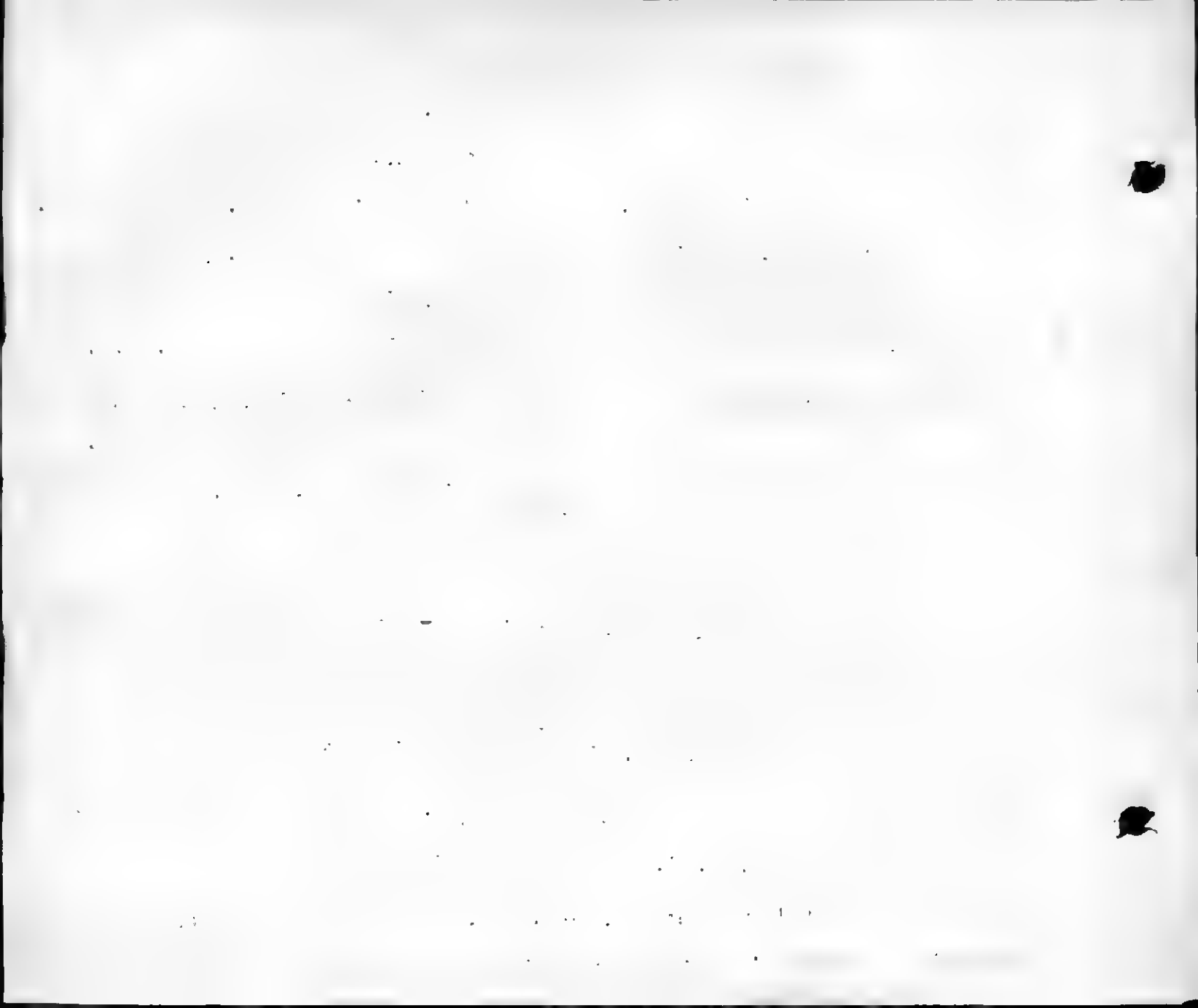
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

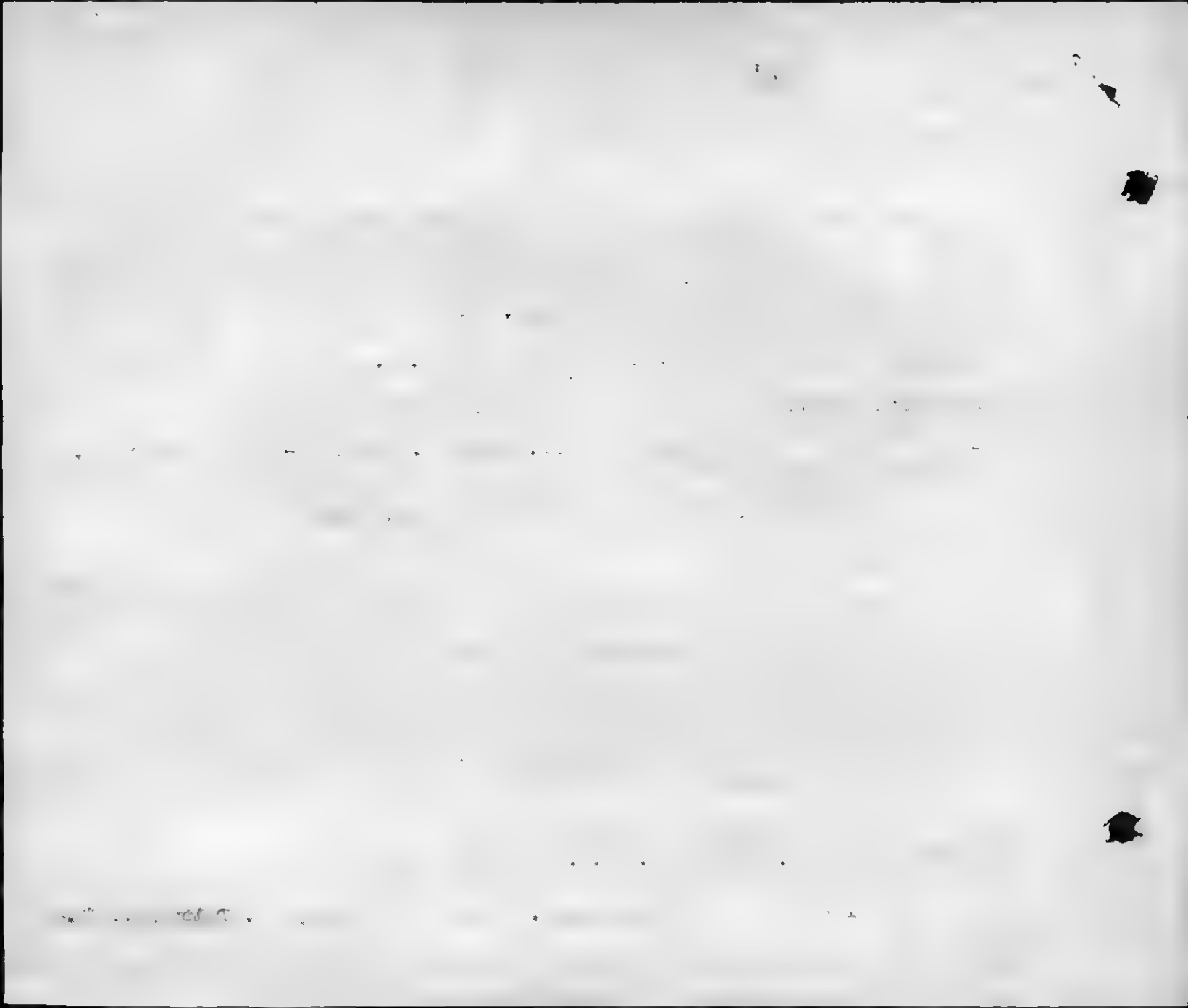


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

11030  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Idlewild</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6315 Banbury Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Idlewild</b> d. STREET ADDRESS <b>6315 Banbury Road</b>	
3. NAME OF DECEASED (Type or print) <b>MARGARETHA LUCILLE DRECHSLER</b>		4. DATE OF DEATH <b>October 16, 1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 29, 1894</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR: Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>N. Y.</b>	
13. FATHER'S NAME <b>Maximillian Waizman</b>		14. MOTHER'S MAIDEN NAME <b>Leonora Kilgen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Ernest F. Drechsler - 6315 Banberry Rd.</b>		Address <b>6315 Banberry Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive thoracic hemorrhage</b> DUE TO <b>rupture of dissecting aneurysm of aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>11/15</b> DUE TO (c) <b>11/15</b>		INTERVAL BETWEEN ONSET AND DEATH <b>PARTIAL</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>11/15</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>11/15</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>11/15</b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>PARTIAL</b>		20f. (City or town) <b>PARTIAL</b> (County) <b>PARTIAL</b> (State) <b>PARTIAL</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. <b>William V. Lovitt, Jr.</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>10/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or country) <b>Woodlawn, Mt. Vernon, New York</b>	
23. FUNERAL DIRECTOR <b>William V. Lovitt, Jr.</b>		ADDRESS <b>11/15</b>	
24a. REC'D BY REGISTRAR <b>OCT 19 1959</b>		24b. REGISTRAR'S SIGNATURE <b>William V. Lovitt, Jr.</b>	



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11009

## CERTIFICATE OF DEATH

Reg. Dist. No.

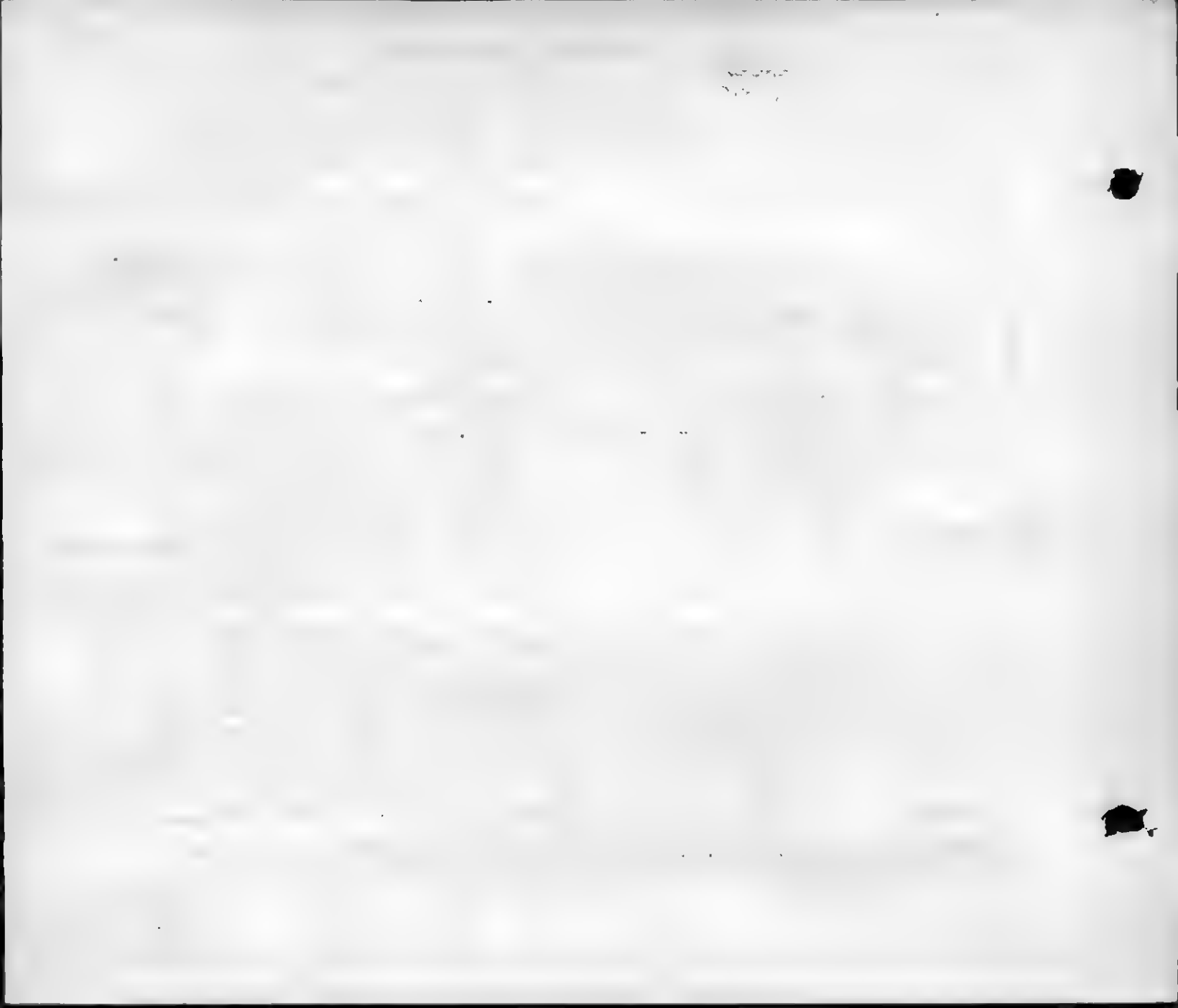
11031

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>				c. LENGTH OF STAY IN 1b <b>53 Dundalk 22</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3143 Baybriar Road</b>				d STREET ADDRESS <b>3143 Baybriar Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>KOERT</b> Middle <b>+++++</b> Last <b>DUBOIS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>6th</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 11th, 1892</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Crib</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry K. DuBois</b>				14. MOTHER'S MAIDEN NAME <b>Florence Bracey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WWII</b>				16. SOCIAL SECURITY NO <b>261-18-1335</b>		17. INFORMANT <b>Veda K. DuBois</b> Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma of the Lung - 13 mos.</b> DUE TO <b>Bates - arthritic change of the lumbar spine</b> DUE TO <b>Hypertension (Essential)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>13 mos.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>7001 Mornington Road</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>July 3, 1953</b> to <b>Oct 6, 1959</b> that I last saw the deceased alive on <b>Oct 6, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7001 Mornington Road</b> DATE SIGNED <b>10/8/59</b>							
ACTUAL SIGNATURE <b>Eugene F. Nevy</b>				M.D. <b>7001 Mornington Road</b>			
PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy, M.D.</b>				<b>Baltimore 22, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Orange, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter L. Brooks Bradley, Inc.</b>				ADDRESS <b>Dundalk 22</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur R. Hines</b>							

MEDICAL CERTIFICATION

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 10b Film G252 11-23-59 et

## CERTIFICATE OF DEATH

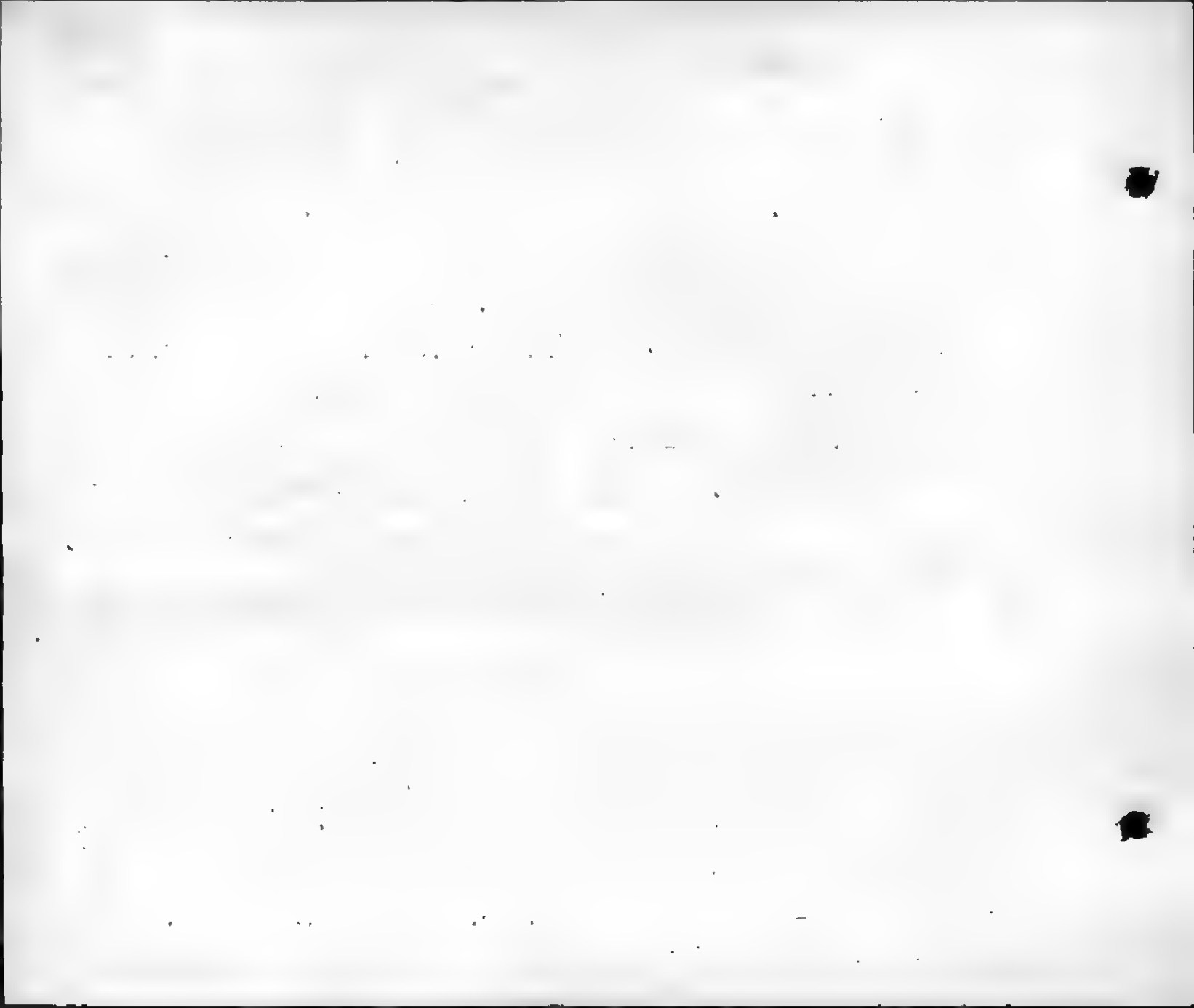
11032

11065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4403 Kenwood Ave.</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4403 Kenwood Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Boggs</b> Last <b>Durgin</b>		4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18-1889</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months <b>69</b>	11. IF UNDER 24 HRS Hours <b>69</b> Min <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shearer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Durgin</b>		14. MOTHER'S MAIDEN NAME <b>Helen Rosenbrock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>213-09-8315</b>	
INFORMANT <b>Marie Durgin</b>		Address <b>4403 Kenwood Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas &amp; Liver Metastasis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Chr. Bronchitis &amp; Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 mos.</b> INTERVA. BETWEEN ONSET AND DEATH <b>1955</b> <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-7-1955</b> to <b>10-30-1959</b> that I last saw the deceased alive on <b>10-30-1959</b> and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3105 N. Charles St. Baltimore, 18 Md.</b> DATE SIGNED <b>11-2-59</b>			
ACTUAL SIGNATURE <b>Robert H. Silver</b>		M.D. <b>3105 N. Charles St. Baltimore, 18 Md.</b>	
PHYSICIAN'S NAME (Type) <b>R. H. Silver</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-3-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Luth. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Hand Home 7401 Belair Rd.</b>			
24a. REC'D BY REGISTRAR <b>NOV 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RYMAN 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5105 S. Rolling Road</b>		d. STREET ADDRESS <b>5105 S. Rolling Road</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS SIDNEY EARP</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR GROCERY STORE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Edward EARP</b>		14. MOTHER'S MAIDEN NAME <b>JULIE NEWTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-4885</b>	
17. INFORMANT <b>MRS. BERTHA EARP</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> INDEX Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Fracture dislocation of 4th cervical vertebra</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fell down steps at home</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>House PARTIAL Relay Baltimore Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10/29/1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House PARTIAL Relay Baltimore Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>10/29/59</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MELVILLE METHODIST CEM.</b>		22d. LOCATION (City, town, or country) (State) <b>Elkridge 27, Md.</b>	
23. FUNERAL DIRECTOR <b>Easton Sons, Catonsville 28, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 4 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur P. K.</b>	



## 11010 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Cottage Ave.</u>				STREET ADDRESS (If rural give location) <u>7 Cottage Ave.</u>			
3. NAME OF DECEASED: (First) <u>Susie</u> (Middle) <u>J.</u> (Last) <u>Edwards</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>10-26</u> <u>1959</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>1-26-1888</u>	
9. AGE last birthday <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		11. BIRTHPLACE (State or foreign country): <u>Prince Edward Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Jackson</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-205113-A</u>			
17. INFORMANT & ADDRESS: <u>Harold Dupree, Jr., E. Md. Box 132</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>444X</u> <u>Virus pneumonia</u>				5 days			
ANTECEDENT CAUSE (B) <u>Arteriosclerosis, Hypertension, Hypertrophy</u>				unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-21</u> , 19 <u>59</u> to <u>10/26/59</u> , that I last saw the deceased alive on <u>10/26/59</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Thomas</u>		M. D.		ADDRESS <u>107 N. Main St. Balto 22 Md.</u>		DATE SIGNED <u>10/28/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-29-59</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>59</u>		REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>		24. FUNERAL DIRECTOR ADDRESS <u>Neidigh J. Collick 1412 E. Boston St.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

11066

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN IB <b>42yr9mth16dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Govans, Maryland</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lydie</b> Middle <b>Ehman</b> Last <b>Ehman</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886 ?</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Ehman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ida Dellihunt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochanteric fracture of left femur</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>on 6-19-59 slipped on wet floor and fell striking left hip</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8:35</b> p.m. <b>6-19</b> <b>19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Md.</b>	
21. I certify that I attended the deceased from <b>June 19</b> , 19 <b>59</b> , to <b>Oct. 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 2</b> , 19 <b>59</b> , and that death occurred at <b>8:35 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 10-5-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>10-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SPRING GROVE STATE HOSP.</b>	22d. LOCATION (City, town, or county) (State) <b>Catonsville 28, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <b>OCT 15 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11067

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 NAME OF DECEASED  
(Type or Print)

Alice W. Enos

2. DATE  
OF  
DEATH

Oct. 24, 1959

3. PLACE OF DEATH

A Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence  
A STATE B. COUNTY before admission)

MARYLAND

B FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

605 Aldershot Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE - 29

D. STREET ADDRESS (If rural, give location)

605 Aldershot Rd.

c Length of stay in Baltimore

95 yrs.

Yrs.  
Mos.  
Days

5 SEX

Female

6 COLOR OR RACE

White

7 SINGLE MARRIED

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov. 18, 1855

9 AGE (In year  
last birthday)

103

10 Under 1 Year  
Months: Days11 Over 24 Hours  
Hours: Min.10A USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B KIND OF BUSINESS OR  
INDUSTRY

11 BIRTHPLACE (State or foreign country)

Richmond Virginia

12 CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Mortimer W. DeShazo

14. MOTHER'S MAIDEN NAME

Letitia Allmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO

17 INFORMANT 605 Aldershot Rd

Mrs. Joseph A. Bennett

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Thrombosis  
due to advanced arteriosclerosis  
and hypertension cardiovascular  
disease

2 days

443 X ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST

DUE TO

(C)

(years)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING ITIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I AS PART II  
21D TIME (Month) (Day) (Year) (Hour)  
OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21E INJURY OCCURRED

21F HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I certify that (I) (the hospital) attended the deceased from  
24 Oct 1959, that (I) ( ) last saw the deceased alive on  
and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23A SIGNATURE

Emil H. Hanning Jr

23B ADDRESS

601 Winans Way

23C. DATE SIGNED

24 Oct 59

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐24A. BURIAL, CREMA  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/26/1959

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto Md.

(State)

DATE REGISTERED  
LOCAL REGISTRAR

10/26/1959

REGISTER'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

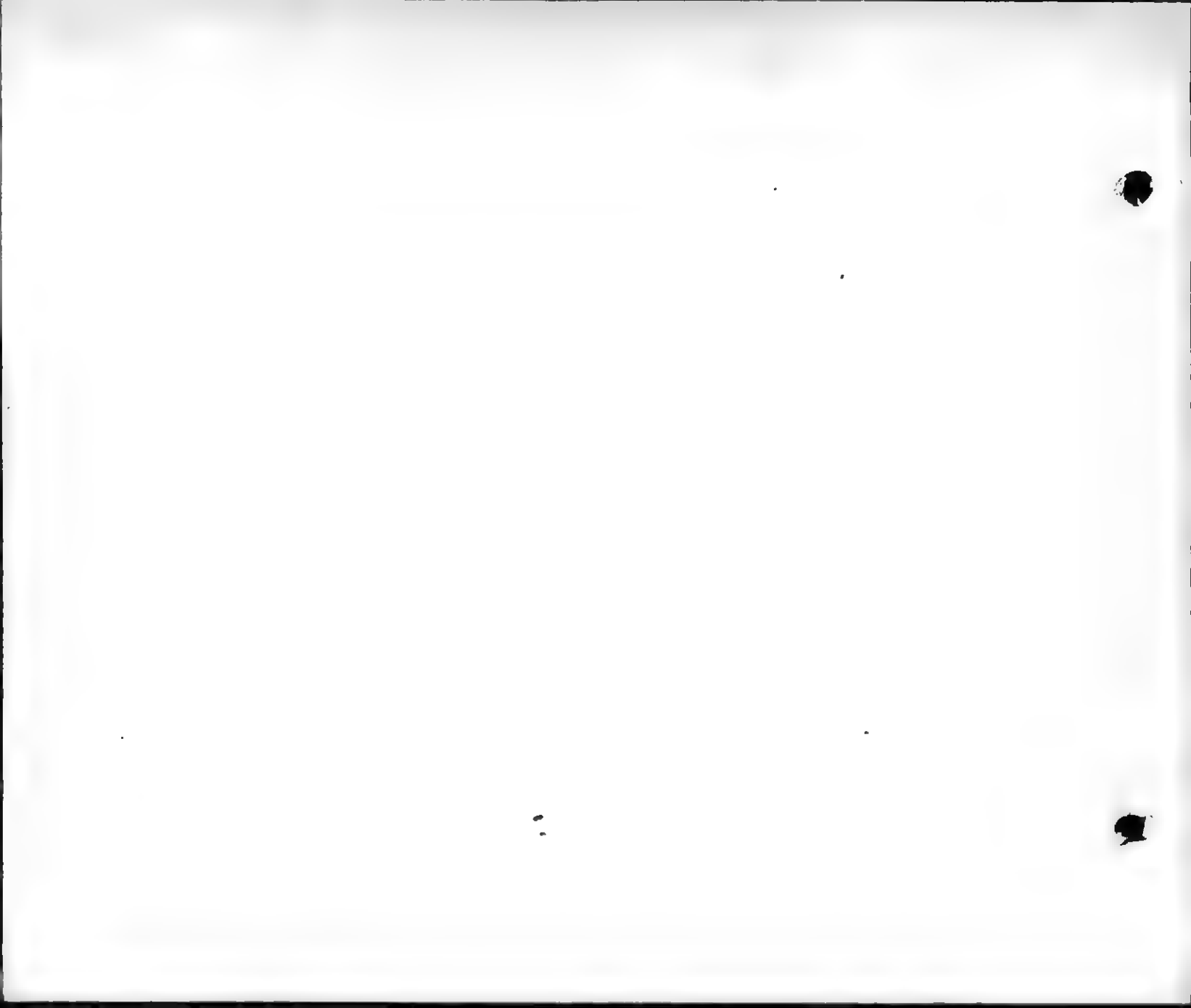
S. T. Tuman

ADDRESS

Schwab

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11037

11068

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS (If rural give location)	
TOWN		<u>6 YEARS</u>		<u>168 OAKLEE VILLAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>168 OAKLEE VILLAGE</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NENA</u> (Middle) <u>MAY</u> (Last) <u>ENSOR</u>				(Month) <u>OCT</u> (Day) <u>9</u> (Year) <u>1959</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>12/18/1894</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u>AT HOME</u>		<u>FREDERICK COUNTY</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOSHUA H. SUNDERGILL</u>				<u>CORNELIA DUDDERAR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NO</u>		<u>MRS. POWELL OAKLEE VILLAGE MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Cardio-vascular Disease</u>				<u>2 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 8</u> , 19 <u>59</u> , to <u>OCT 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 7</u> , 19 <u>59</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George E. Shannon M.D.</u>				ADDRESS (Street, city, town, state) <u>412 Medical Arts Bldg</u>		DATE SIGNED <u>OCT 8, 1959</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10/12/59</u>		<u>LINGBROOK</u>		<u>UNIONVILLE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>OCT 13 '59</u>		<u>Arthur B. Kraus</u>		<u>W. Hartzler Lane</u>		<u>Libertytown MD</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

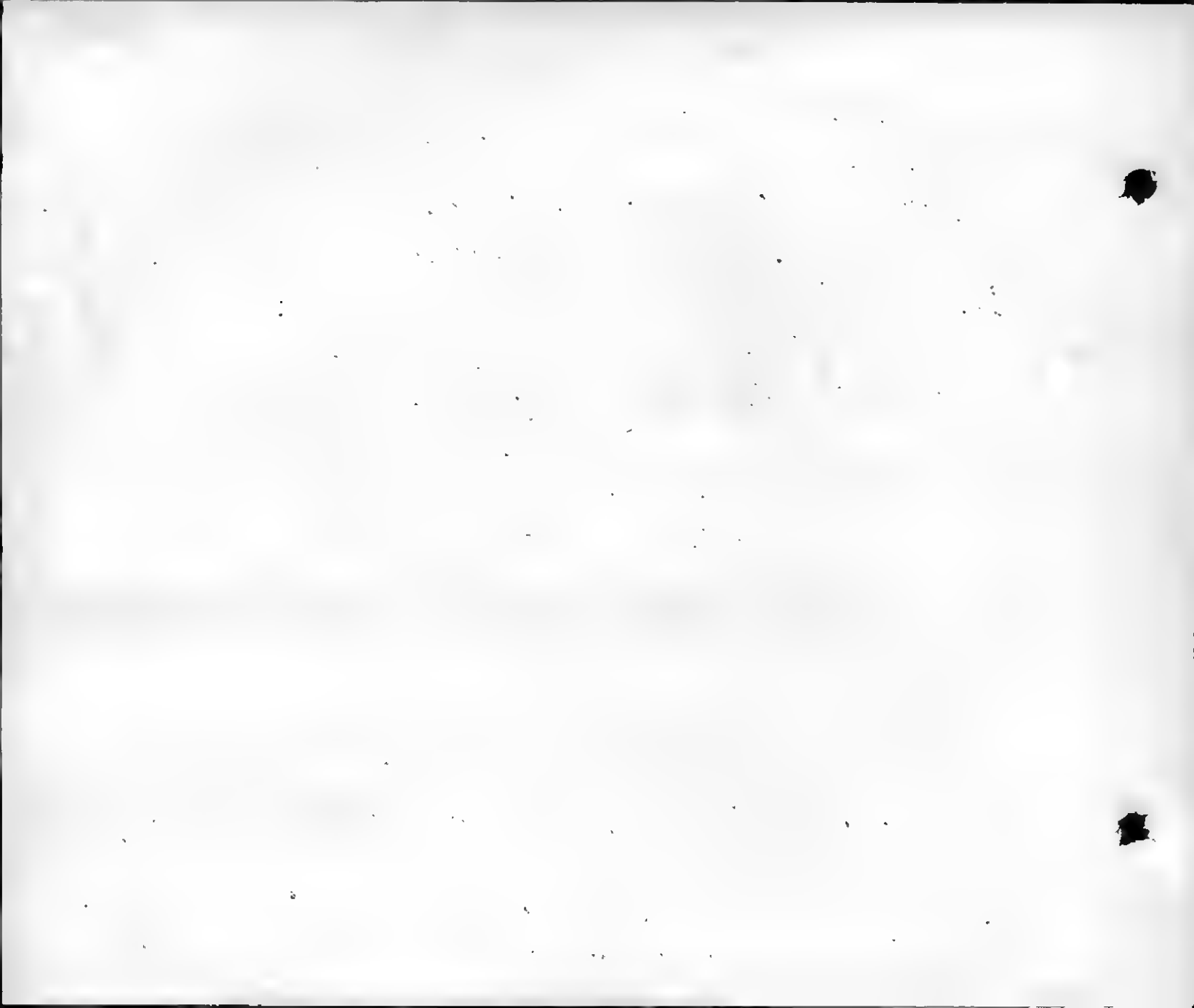
11069

CERTIFICATE OF DEATH

11038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Foxlegh Nursing Home</u>		e. STREET ADDRESS <u>3302 Dorchester Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Yetta</u> Last <u>Epstein</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>6</u> - Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1899</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Austria</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Weiss</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Morris Epstein - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC KIDNEY DISEASE</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIBETES MELLITUS &amp; Cerebral THROMBOSIS.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>58</u> , to <u>OCT 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 6</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis T Daly</u>		ADDRESS (Street, city or town, state) <u>1725 RIVERSTOWN RD BALTIMORE</u>	
PHYSICIAN'S NAME (Type) <u>OCT 7</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		22d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>		ADDRESS <u>2100 GUTAW PLACE</u>	
24a. REC'D BY REGISTRAR <u>OCT 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11070

## CERTIFICATE OF DEATH

Reg. Dist. No.

11039

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN TB <b>6 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6001 Cecil Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Frances</b> Last <b>Fanning</b>				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1891</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min <b>68</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Station Operator American Oil Co. Cincinnati, Ohio</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cincinnati, Ohio</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Frank W. Fanning</b>				14. MOTHER'S MAIDEN NAME <b>Mary Agnes Iglehart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-05-6424</b>		17. INFORMANT <b>William F. Fanning, Jr.</b> Address <b>3902 Buckingham Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Intoxication C-V-K Disease</b> <b>Alcoholic Intoxication</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>12 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>42</b> to <b>10-21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-20</b> , 19 <b>59</b> , and that death occurred at <b>21</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John A. Coleman</b> M.D.				ADDRESS (Street, city or town, state) <b>5907 Pungin Oak Ave. Balt. Md.</b> DATE SIGNED <b>11 23 59</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederic A. Cole</b> ADDRESS <b>1913 W. Balto. St.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 26 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Thayer</b>	



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

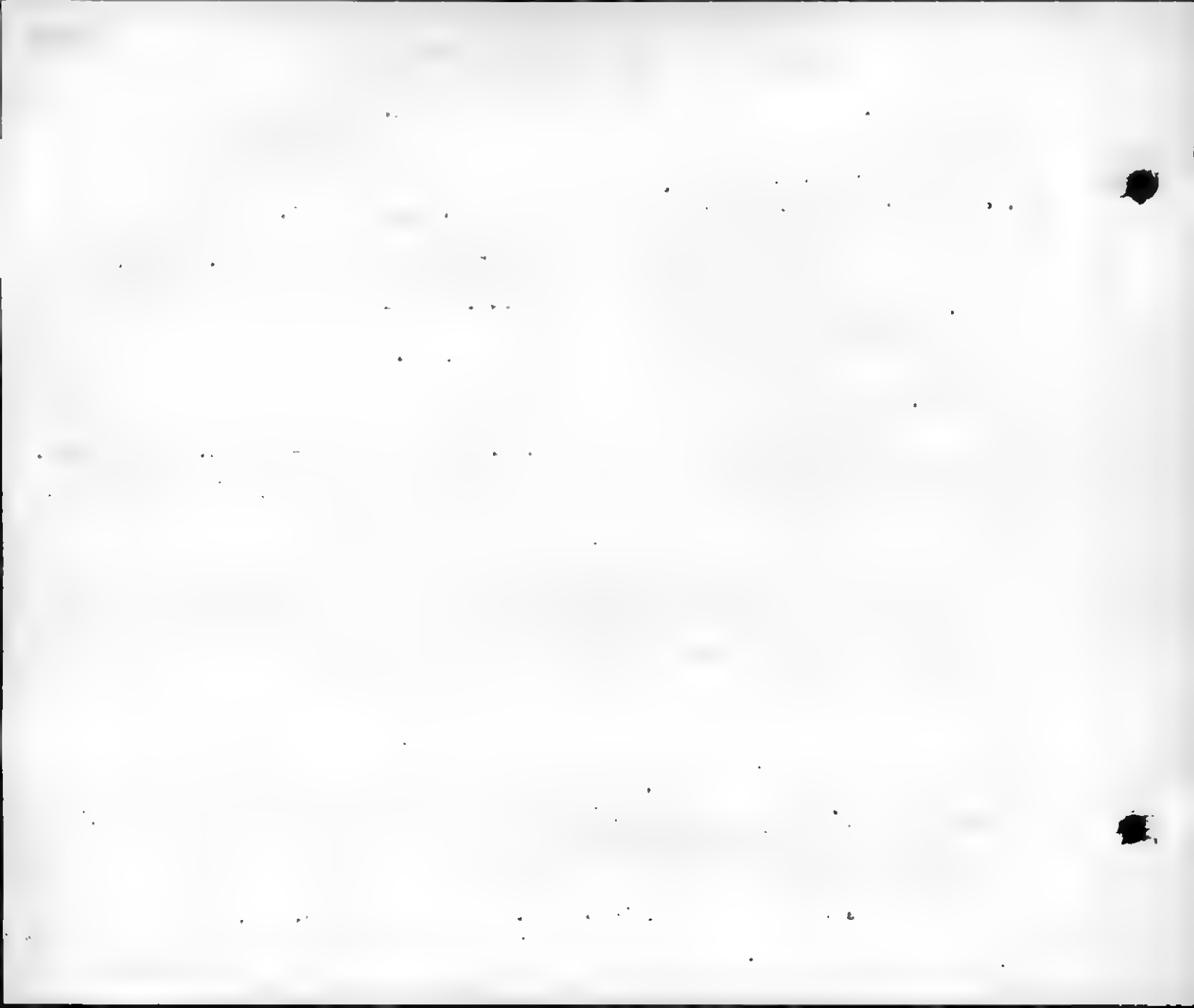
11071

CERTIFICATE OF DEATH

Reg. Dist. No.

11040

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION <b>5743 Edmondson Ave. Ridgeway Manor Nursing Home</b>				d. STREET ADDRESS <b>3717 W. Garrison Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>REBA</b> Middle <b>RALLYA</b> Last <b>FARRELL</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 25, 1891</b>	
9. AGE (In years lost birthday) <b>68</b> yrs		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min <b>68</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Silas F. Rallya</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Hogg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mr. F. Edward Farrell - 3717 W. Garrison Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebrovascular disease</b> DUE TO (c) <b>2 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>48 hrs</b> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 16, 1959</b> to <b>Oct. 18, 1959</b> that I last saw the deceased alive on <b>Oct. 16, 1959</b> and that death occurred at <b>3:15 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6014 Edmondson Ave. Balto., Md.</b> DATE SIGNED <b>10/19/59</b>							
ACTUAL SIGNATURE <b>J. Nelson McKay</b> M.D.							
PHYSICIAN'S NAME (Type) <b>J. Nelson McKay</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickers &amp; Sons - Trustees</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	





11072

CERTIFICATE OF DEATH

11041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #15</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6617 Parsons av</u>		e. STREET ADDRESS <u>4200 Menlo Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie E. Follmeyer</u> First Middle Last		4. DATE OF DEATH <u>Oct 29 1959</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ned McGuire</u>		14. MOTHER'S MAIDEN NAME <u>Lusie O'Neil</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mrs. Mary E. McCarty</u> Address <u>6617 Parsons av.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis C.V.D.</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 11, 1954</u> to <u>28 Oct 1959</u> , that I last saw the deceased alive on <u>28 Oct 1959</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1632 Pikesville Road</u> DATE SIGNED <u>Pikesville 8, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Oct. 31, 1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS <u>Pikesville, Md.</u>		24. REG'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 3 '59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

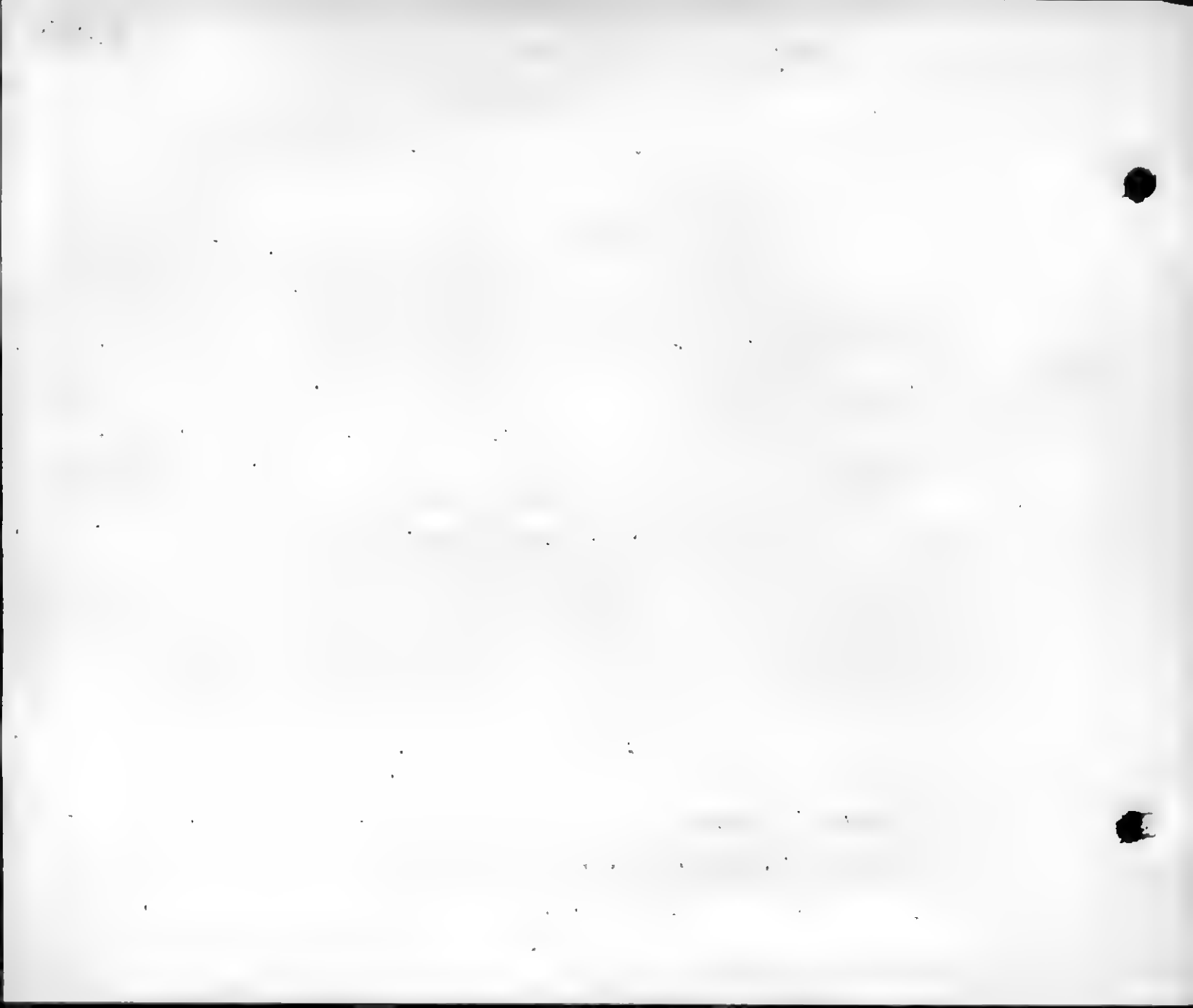
11073

CERTIFICATE OF DEATH

11042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN lb <b>8 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nicodemus Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>Nicodemus Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Forbes</b> Last <b>Forbes</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 18, 1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min		11. BIRTHPLACE (State or foreign country) <b>Geneseo, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired school teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Edward James Forbes</b>				14. MOTHER'S MAIDEN NAME <b>Fidelia R. Rider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		INFORMANT Address <b>Charles A. Forbes, Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastasis</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>malignancy left breast</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>  <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 4, 1956</b> , to <b>October 3, 1959</b> , that I last saw the deceased alive on <b>October 3, 1959</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Martin E. Strobel</b>				ADDRESS (Street, city or town, state) <b>48 Main St. Reisterstown</b>		DATE SIGNED <b>10-5-59</b>	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Temple Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Geneseo, Livingston Co. N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Frank</b>	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 10-15-59 et

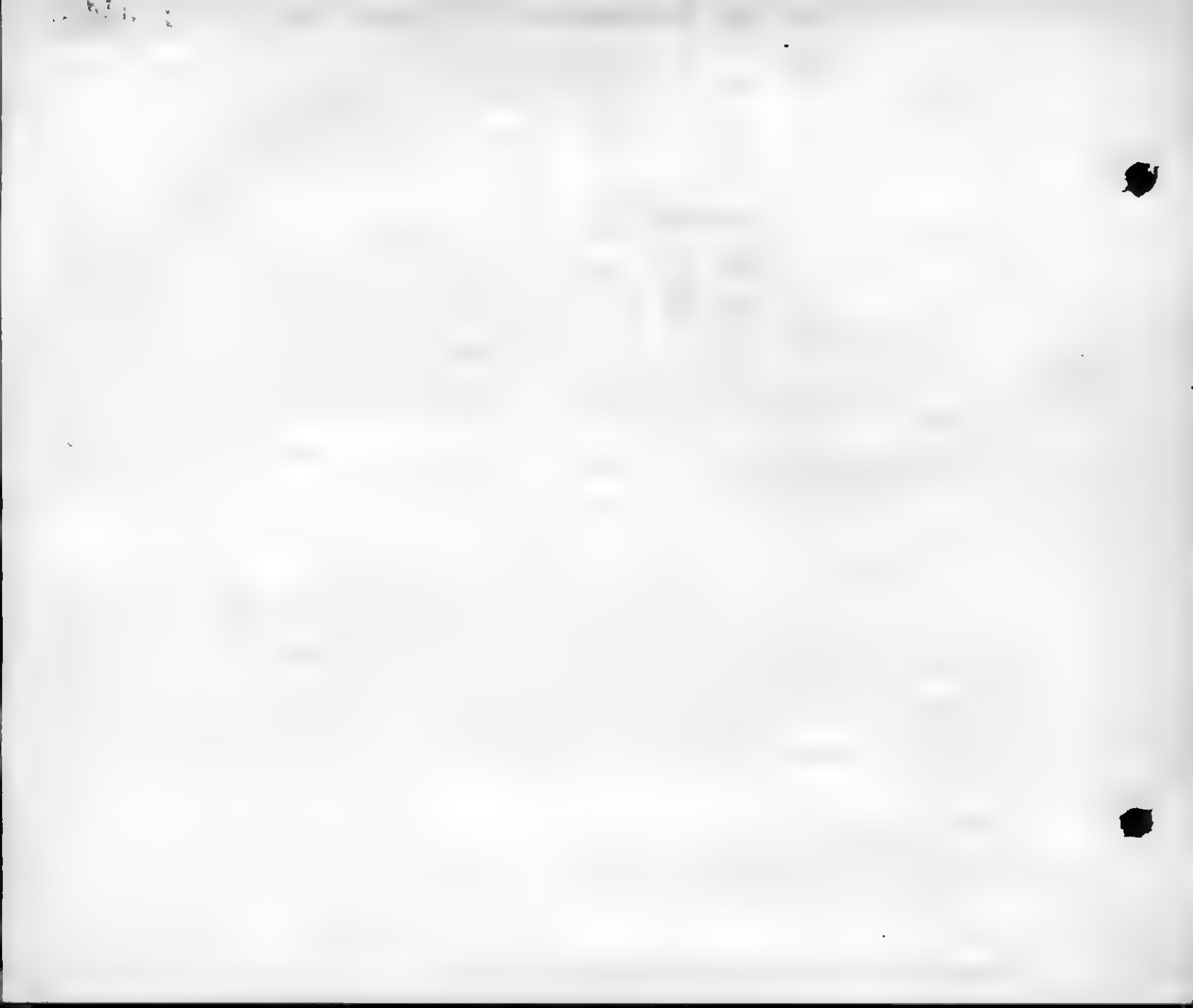
11043

11074

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Timonium</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Timonium</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Timonium</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>112 Gorsuch Road</i>				d. STREET ADDRESS <i>112 Gorsuch Road</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>LILLIAN N FORD</i>				4. DATE OF DEATH Month Day Year <i>Oct 7 1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 30, 1902</i>	9. AGE (In years last birthday) <i>57</i> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Dorchester, Co., Md.</i>	
13. FATHER'S NAME <i>J. Passgeon Robinson</i>				14. MOTHER'S MAIDEN NAME <i>Nettie M. Kinnaman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>20</i>			
17. INFORMANT Address <i>Mr Robert Ford, 615 St Dunstan Rd.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>							
DUE TO (b) <i>Carcinoma of esophagus</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>-</i>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Sept 10, 1959</i> to <i>Oct 7, 1959</i> , that I last saw the deceased alive on <i>Oct 6, 1959</i> , and that death occurred at <i>8:05 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>M. K. Quinn</i>				ADDRESS (Street, city or town, state) <i>1925 York Rd, Timonium</i>			
PHYSICIAN'S NAME (Type) <i>M. K. QUINN</i>				DATE SIGNED <i>10/7/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 9, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Henry W. Jenkins &amp; Sons, Co. 4905 York Road</i>				24. REC'D BY REGISTRAR DATE <i>OCT 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Cathy S. Kneass</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

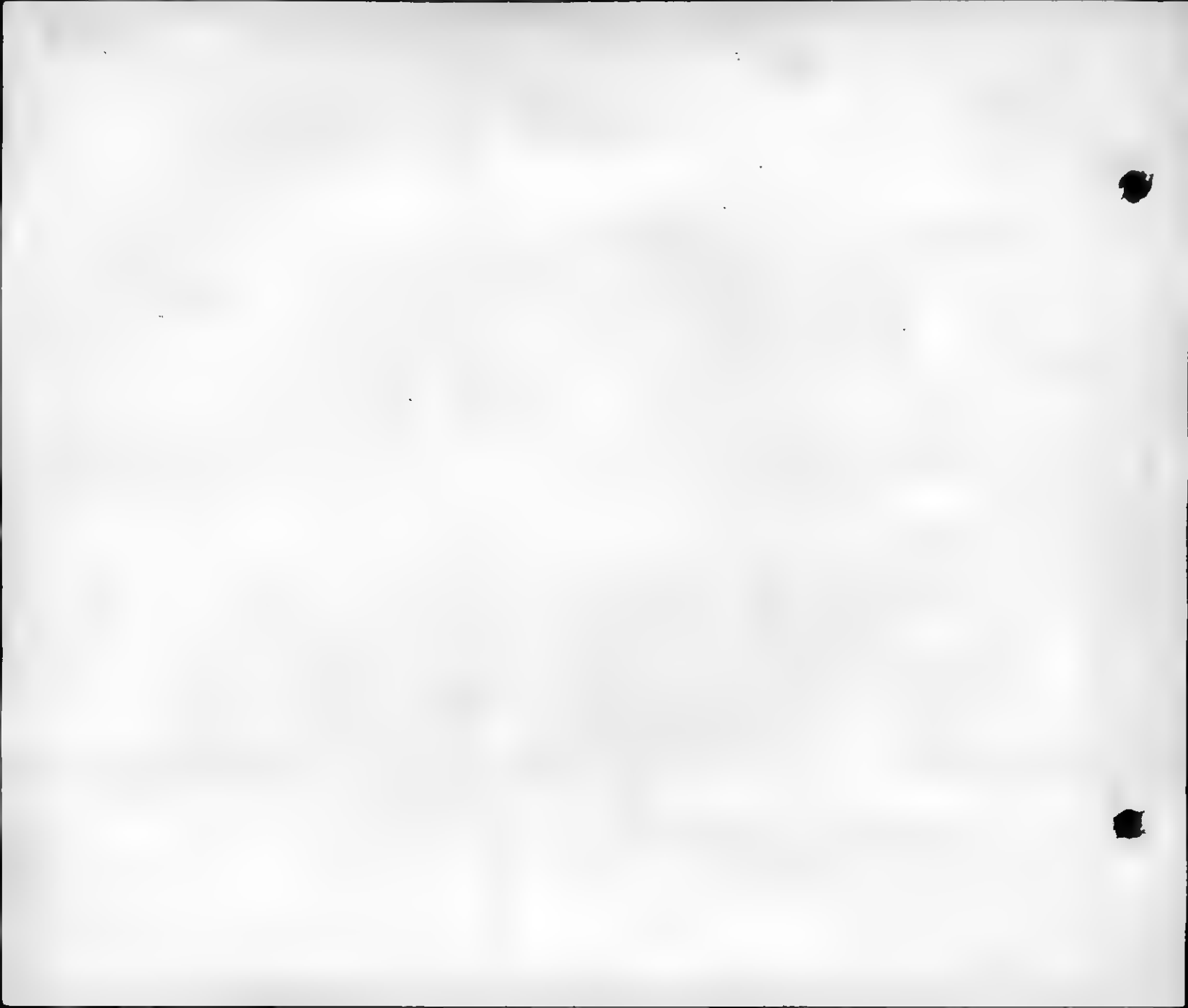
11044

11075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>45 KERRIA LANE (20)</u>		e. STREET ADDRESS <u>45 KERRIA LANE (20)</u>	
3. NAME OF DECEASED (Type or print) <u>THERESA FOREMAN</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-95</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BUTZNER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-26-6320</u>	
17. INFORMANT <u>MR. DAVID FOREMAN (SAME AS ABOVE)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension @-V-Disease</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>	
ADDRESS <u>418 Eastern Blvd.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. For State Health Dept. File pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11076

## CERTIFICATE OF DEATH

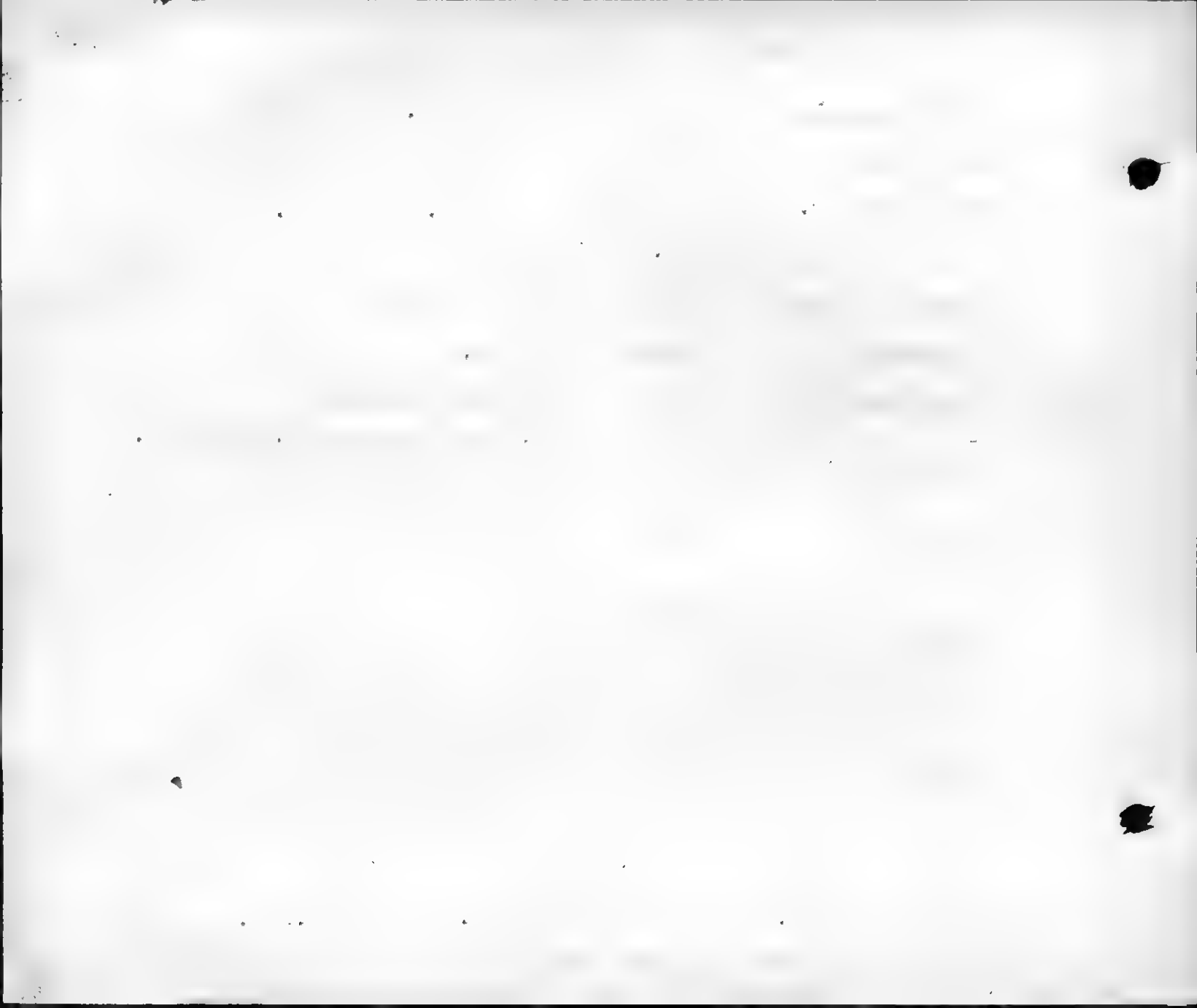
11045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b> <b>98 Smithwood Ave.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>456 S. Bentalou St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Gaffney</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min <b>16</b>	11. IF UNDER 24 HRS. Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min <b>16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis Zentgraf</b>		14. MOTHER'S MAIDEN NAME <b>Mary (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> <b>Mrs. Fay Gaffney - 454 S. Bentalou St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>1042</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , to <b>Oct 16, 1959</b> , that I last saw the deceased alive on <b>Oct 16, 1959</b> , and that death occurred at <b>7:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>10.16.59</b>			
ACTUAL SIGNATURE <b>Justinus Rudolph</b> M.D.		21b. SIGNATURE OF REGISTRAR <b>10.16.59</b>	
PHYSICIAN'S NAME (Type) <b>Justinus Rudolph</b>		21c. SIGNATURE OF REGISTRAR <b>10.16.59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/20/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Siskind &amp; Sons - Balto. 17, Md.</b>		24. REC'D BY REGISTRAR <b>1959</b>	
25. REGISTRAR'S SIGNATURE <b>Christina S. Thomas</b>		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11077

CERTIFICATE OF DEATH

11046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5153 Baltimore Nat.Pike</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>B.</b> Last <b>Galloway</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>22,</b> Year <b>19 59</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1865</b>
9. AGE (In years last birthday) <b>94</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter C. Leiritz</b>		14. MOTHER'S MAIDEN NAME <b>Margareta Bauer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Address <b>Mrs Marguerite Dickey, 5151 Balto. Nat. Pike</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, Generalized</b> <b>450</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 8,</b> 19 <b>58,</b> to <b>Oct. 22,</b> 19 <b>59,</b> that I last saw the deceased alive on <b>Oct. 21,</b> 19 <b>59,</b> and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave., Baltimore 29, Maryland.</b> DATE SIGNED <b>10/23/59</b>			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>Leo J. Gaver, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>		<b>Baltimore 29, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[The text in this section is extremely faint and illegible. It appears to be a list or a series of entries, possibly names or dates, arranged in a structured format. Some faint words like "List" or "Table" might be visible at the top, but the rest is too blurry to transcribe accurately.]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11078

## CERTIFICATE OF DEATH

Reg. Dist. No.

11047

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 Wolf Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ella Gertrude</b> Middle <b>Gardner</b> Last <b></b>		4. DATE OF DEATH Month <b>10</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-8-11</b>
9. AGE (In years last birthday) <b>47</b> yrs		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore A. Bosley</b>		14. MOTHER'S MAIDEN NAME <b>Ella Townsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>J. Roy Gardner - Reisterstown, Md.</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary thrombosis</b> DUE TO (b) <b>Thrombo phlebitis left leg</b> DUE TO (c) <b>Hysterectomy for uterine Fibroid 9-12-59</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 mins.</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 1949, to October 2, 1959</b> , that I last saw the deceased alive on <b>October 2, 1959</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>48 Main St., Reisterstown, Md.</b> DATE SIGNED <b>10-3</b>			
ACTUAL SIGNATURE <b>Martin E. Strobel</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>All Saints Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline and Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. J. &amp; H. H.</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11048

11022

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>6</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1558 Sulphur Spring Road</u>		d. STREET ADDRESS <u>1558 Sulphur Spring Rd</u>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK HERMAN GEISELMAN</u>		e. DATE OF DEATH <u>Oct 25 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>25</u> Days <u>25</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Union News Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Geiselman</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or while serving) <u>No</u>		16. SOCIAL SECURITY NO. <u>22-07-7447</u>	
17. INFORMANT <u>Marian L. Byrnes</u>		Address <u>6012 Lepton Ave 14</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma Abdomen</u> DUE TO <u>1520</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Cecum</u> DUE TO (c) <u>3 yes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Carcinoma Pleura left.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1956</u> to <u>Oct 25, 1959</u> , that I last saw the deceased alive on <u>Oct 24, 1959</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Bradley Daugharthy</u> M.D.		ADDRESS (Street, city or town, state) <u>1264 Francis Ave Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>A. B. Daugharthy, M. D.</u>		DATE SIGNED <u>10-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 28 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tangel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11079

## CERTIFICATE OF DEATH

Reg. Dist. No.

11049

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armacost Nursing Home</u>		d. STREET ADDRESS <u>415 Regester ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>GERDING</u> Last <u>GERDING</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>16</u> Days <u>18</u> Hours <u>59</u> Min	11. IF UNDER 24 HRS Months <u>16</u> Days <u>18</u> Hours <u>59</u> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederich Nov</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Lemmitges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Leroy E. Gerding</u>		Address <u>605 Hillen Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Renal Vascular Disease</u> DUE TO <u>57 yr</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 10, 1959</u> to <u>Oct 18, 1959</u> , that I last saw the deceased alive on <u>Oct 17, 1959</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		DATE SIGNED <u>10/19/59</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>		<u>7501 York Rd. Towson 4, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Road</u>	
24a. REC'D BY REGISTRAR <u>OCT 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



## CERTIFICATE OF DEATH

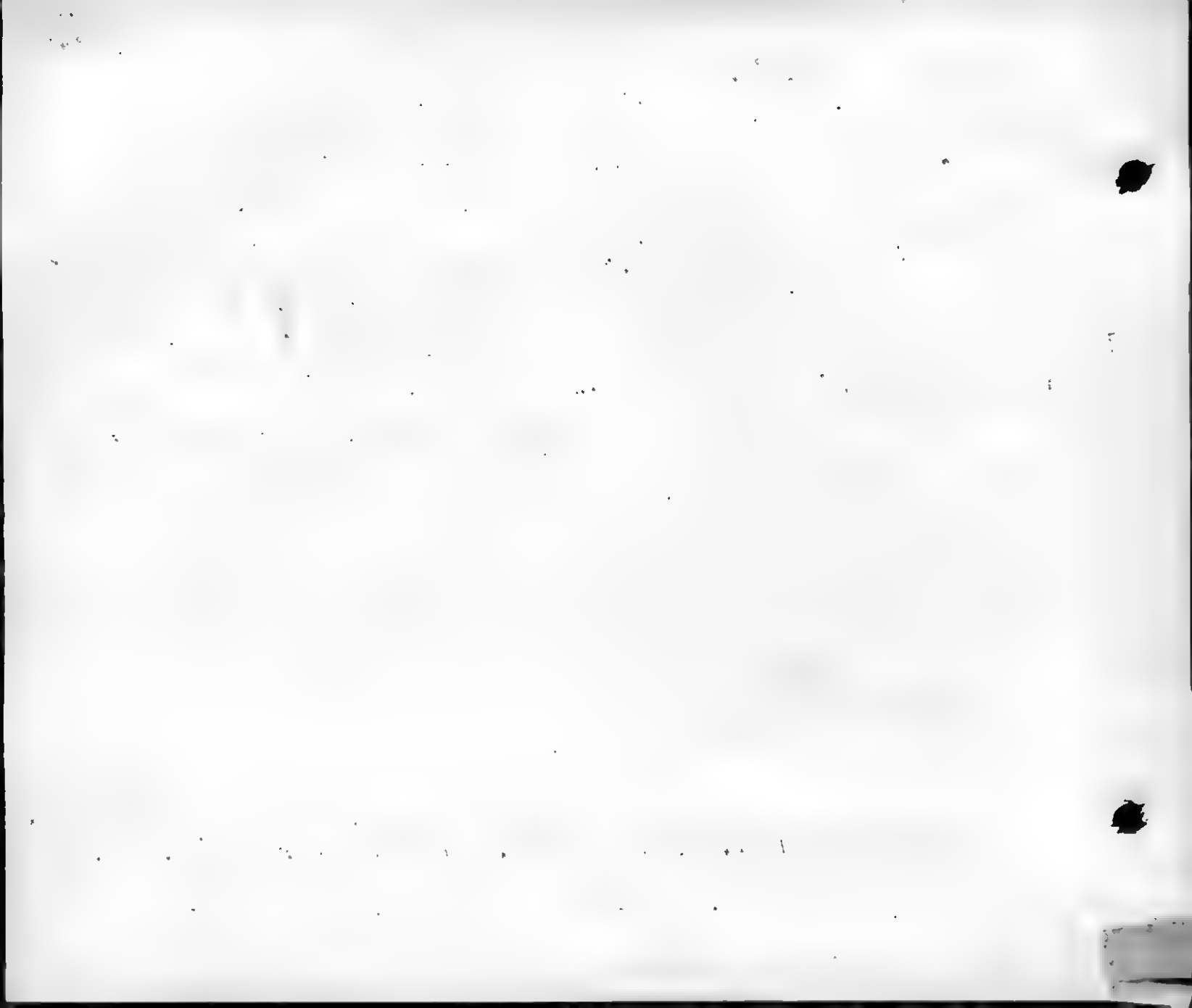
Reg. Dist. No.

11080

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <input checked="" type="checkbox"/> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution and residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>1 mo. 3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>College Manor, aged Home</u>		d. STREET ADDRESS <u>226 Homewood Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Elizabeth</u> Middle <u>Gillilan</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-83</u>
9. AGE (In years, last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Palmerston, Ontario, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel McDowell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4826 Roland Ave, Balto 10</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic C.V. disease</u> <u>432.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/22/54</u> 19 <u>54</u> to <u>10/6/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10/5/59</u> 19 <u>59</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis W. Gluck</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/6/59</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS W. GLUCK</u>		<u>100 W. UNIVERSITY PKWY, BALTO., MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>October 8, 1959</u>	<u>Lutheran Cemetery</u>	<u>Emmitsburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson</u>		ADDRESS <u>Emmitsburg Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	
DATE <u>OCT 8 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

11050

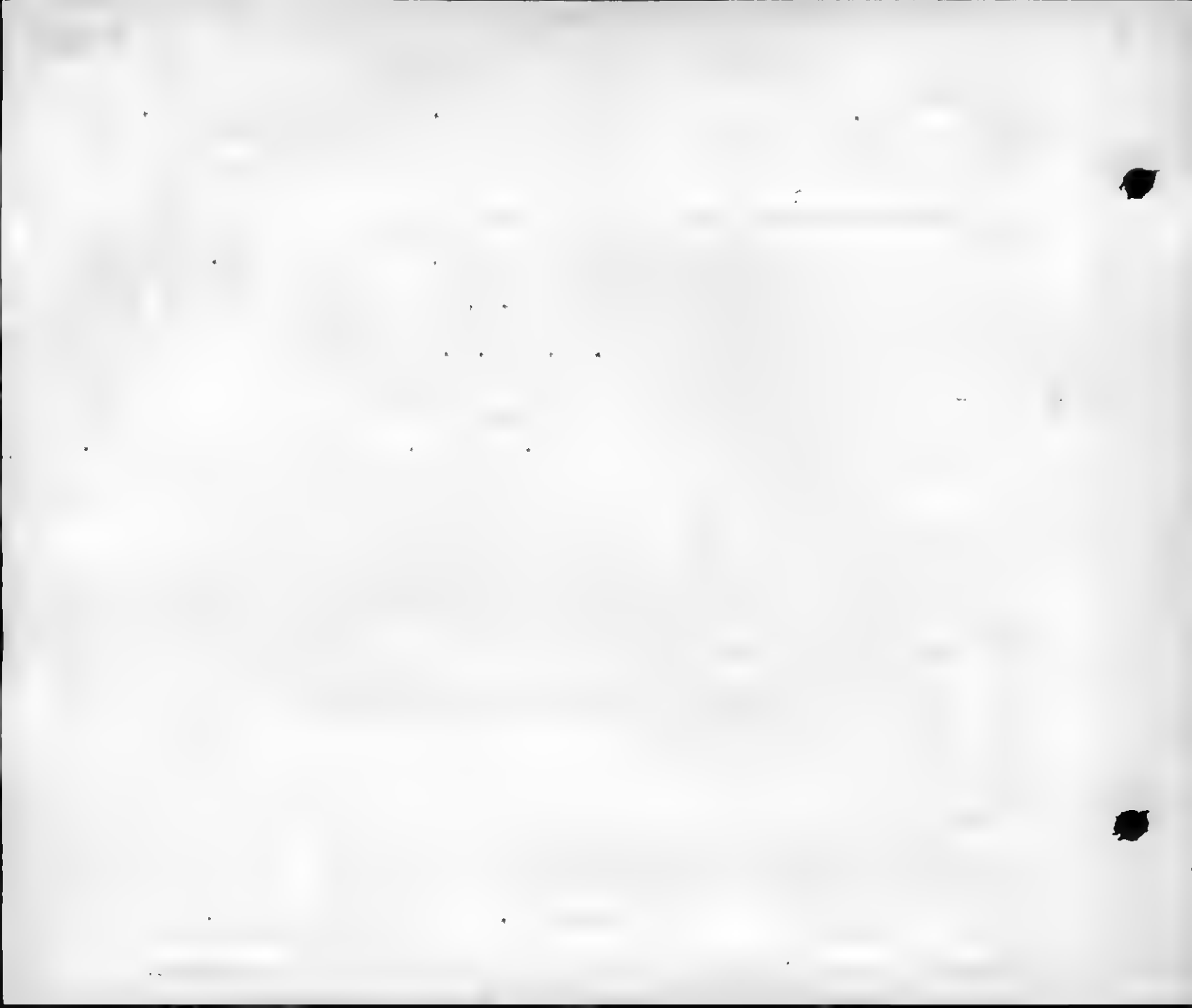
Reg. Dist. No.

11081

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Byway Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Bertram</b> Last <b>Gillem.</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>6,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1887</b>
9. AGE (In years, last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>	
11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY: <b>N. J.</b>	
13. FATHER'S NAME <b>Gillem</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO <b>Mr. Donald D. Jackson - 3801 Arbutus Ave.</b>	
17. INFORMANT <b>Mr. Donald D. Jackson - 3801 Arbutus Ave.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 1957</b> to <b>October 6, 1959</b> , that I last saw the deceased alive on <b>October 5, 1959</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles E. McWilliam, M.D., Pikesville, Md., October 6, 1959</b>			
ACTUAL SIGNATURE <b>Charles E. McWilliam</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. ...</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. McWilliam</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

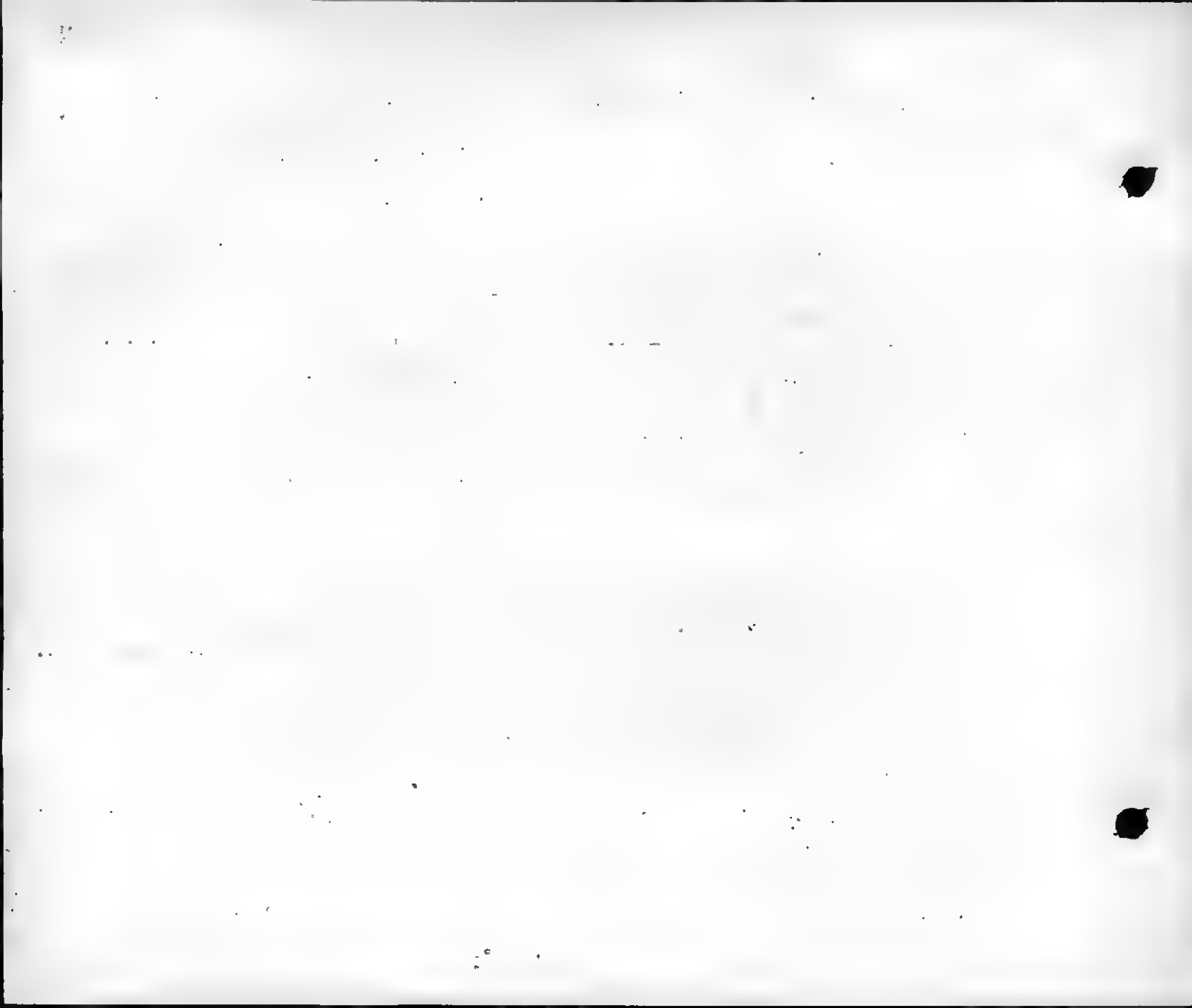
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 20 Film 249 10-15-59 ams - Item 21 Film 3250-10/21/59-mb									
11082									
CERTIFICATE OF DEATH									
Reg. Dist. No. 12238									
1. PLACE OF DEATH a. COUNTY <b>Rosewood State Training School</b> <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>					c. LENGTH OF STAY IN Ib				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>				
f. STREET ADDRESS <b>1814 Wycliffe Road</b>					g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Sally</b> Middle <b>Ann</b> Last <b>Gillis</b>					4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-31-53</b>		9. AGE (In years lost birth day) <b>5</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edward Glenn Gillis</b>					14. MOTHER'S MAIDEN NAME <b>Phyllis May Miller</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO -----		INFORMANT <b>Rosewood Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia due to Aspiration of Stomach Contents</b>									
921.7 DUE TO									
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>Severe Hydrocephalus Due To Arachnoid Cyst Between Anterior and Middle</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fossa since 2 yrs. choked on food</b>				
20c. TIME OF INJURY Month. Day, Year <b>12-31-10 5 1959</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rosewood (bed case) Owings Mills Balto Md.</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>4/23/57</b> 19 to <b>10/13/59</b> 19, that I last saw the deceased alive on <b>4/23/57</b> 19, and that death occurred at <b>12 P. M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Larry G. Butler</b> M.D.					ADDRESS (Street, city or town, state) <b>Owings Mills, Md</b> DATE SIGNED <b>Oct. 5, 1959</b>				
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10/6/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Butler, Penna.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Rd., Towson Md.</b>					24a. REC'D BY REGISTRAR <b>OCT 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Thomas</b>		





11083

CERTIFICATE OF DEATH

11051

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3437 Flannery Lane</u>		d. STREET ADDRESS <u>3437 FLANNERY LANE</u>	
3. NAME OF DECEASED (Type or print) First <u>STUART</u> Middle <u>JAN</u> Last <u>GINSBURG</u>		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	9. AGE (In years last birthday) <u>8</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>12</u> Hours <u>20</u> Min.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY GINSBURG</u>		14. MOTHER'S MAIDEN NAME <u>Rose MATZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Harry Ginsburg - 3437 Flannery Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC BRAIN TUMOR</u> <u>1950</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 12 20</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>city</u> , 19 <u>54</u> , to <u>city</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>59</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Turner</u>		M.D. <u>WEL PARK HEALTH INC</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD TRAMER</u>		DATE SIGNED <u>10/31/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 2 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cong</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal German + 1212</u>		ADDRESS <u>1124-2620 North Ave</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles E. Turner</u>	
DATE <u>NOV 3 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11084

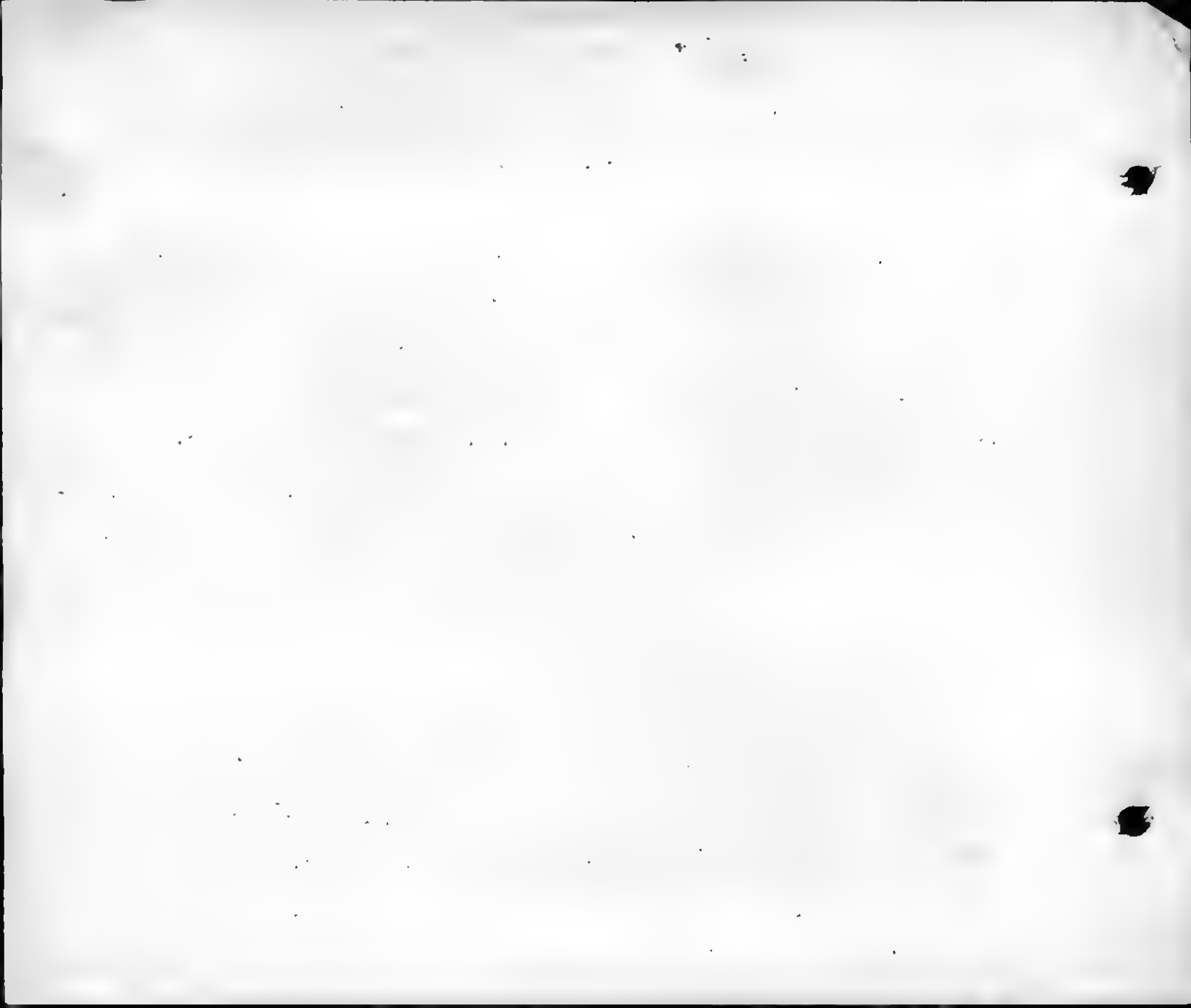
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		c. LENGTH OF STAY IN lb <i>13 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Josephine</i> Middle <i>GLANVILLE</i> Last <i>GLANVILLE</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 6, 1871</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert B. Glanville</i>		14. MOTHER'S MAIDEN NAME <i>Josephine H. Joyce</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. B. F. Emenheiser-Garrison, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> DUE TO (b) <i>Carcinoma of uterus</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>few years</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1947</i> to <i>10 Oct, 1959</i> , that I last saw the deceased alive on <i>10 Oct, 1959</i> , and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H Royce</i>		DATE SIGNED <i>10 Oct 59</i>	
PHYSICIAN'S NAME (Type) <i>Paul H Royce M.D.</i>		<i>Pikesville 8 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J Tiedman &amp; Sons</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 13 '59</i>	
ADDRESS <i>Baltimore 19, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11053

11085

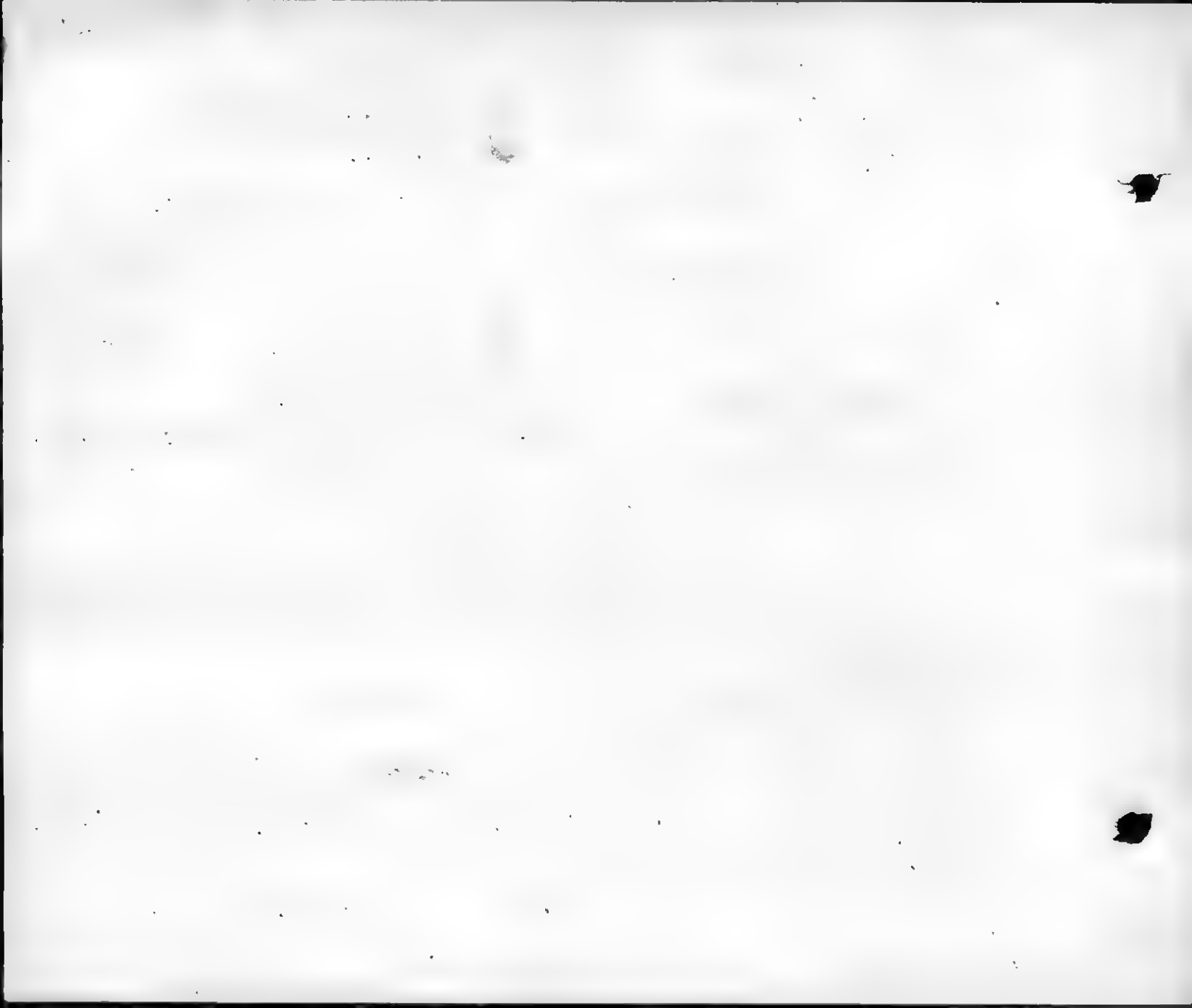
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3529 Flannery Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Gordon</u> Last <u>Gordon</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8, 1935</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR: Months <u>24</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Gordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs Ellen Gordon - 3529 Flannery Lane</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized melanocarcinomatosis</u> DUE TO (b) <u>malignant melanoma</u> DUE TO (c) <u>lymphoma</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May</u> 1959, to <u>10-3</u> 1959, that I last saw the deceased alive on <u>10-3</u> 1959, and that death occurred at <u>11:50 PM</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Joseph Bedgelbaum M.D.</u>		DATE SIGNED <u>10-3-59</u>
PHYSICIAN'S NAME (Type) <u>4017 Liberty Heights Ave. Balt.</u>		

22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bonae Jacobi</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Lennan &amp; Sons Inc</u>		24. REC'D BY REGISTRAR <u>1124 N. North Ave</u>	
24a. DATE <u>OCT 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	



11086

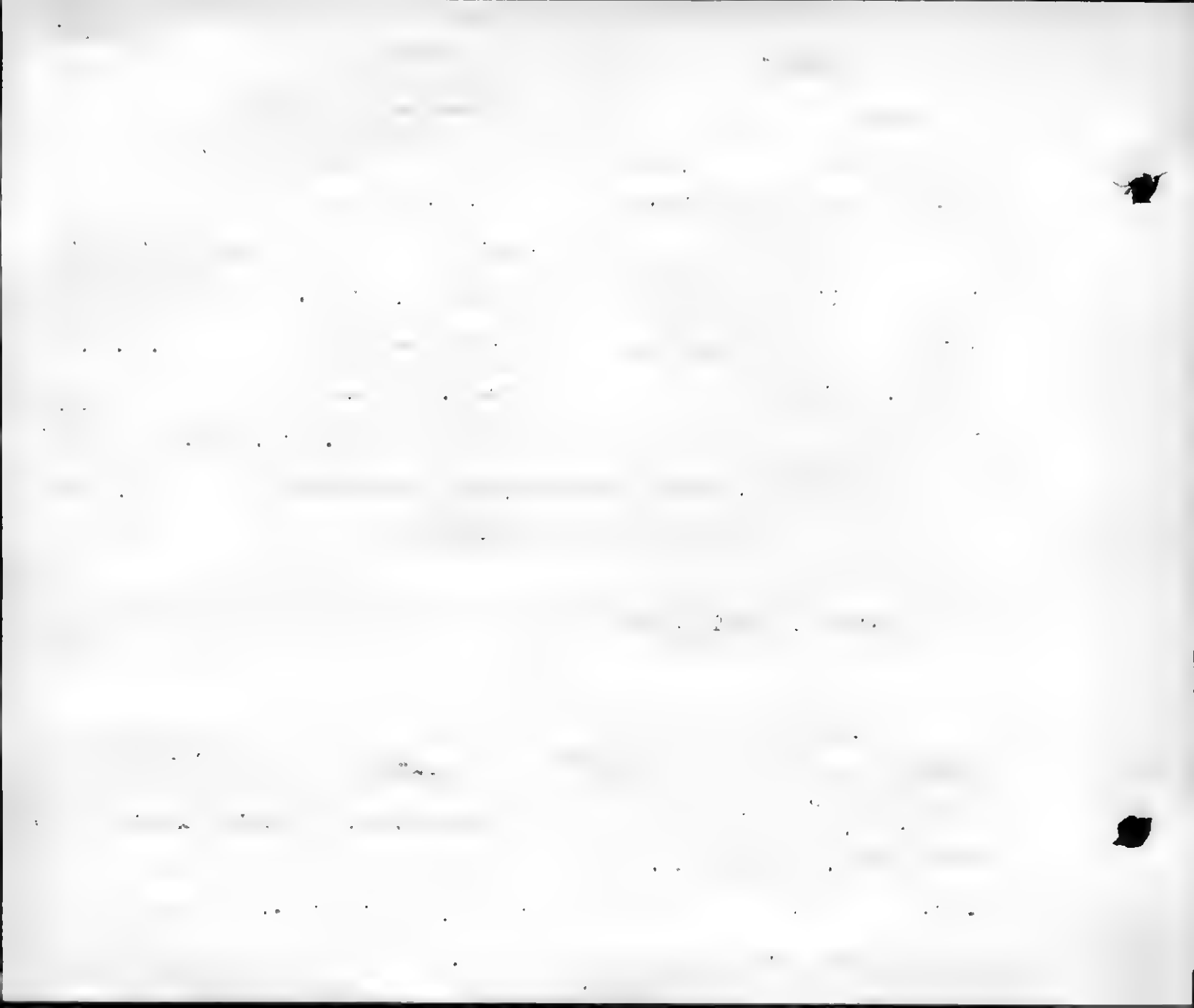
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>31 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(28)</b> d. STREET ADDRESS <b>22 Maple Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>L</b> Last <b>GRIFFITH</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1892</b>
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	11. IF UNDER 24 HRS Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Ewell E. Griffith</b>	
14. MOTHER'S MAIDEN NAME <b>Rosa A. Cleveland</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Division Clinical Records, VAH, Balto. 18, Md. Fort Howard/</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE WITH RIGHT HEMIPLEGIA</b> DUE TO <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UNKNOWN</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>ONE MONTH</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>September 1, 1959</b> , to <b>October 2, 1959</b> , and that death occurred at <b>12:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTO., MD. FORT HOWARD DIVISION</b> DATE SIGNED <b>10/2/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>MacNabb Funeral Home, Frederick and Wade Aves. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 2 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11087

## CERTIFICATE OF DEATH

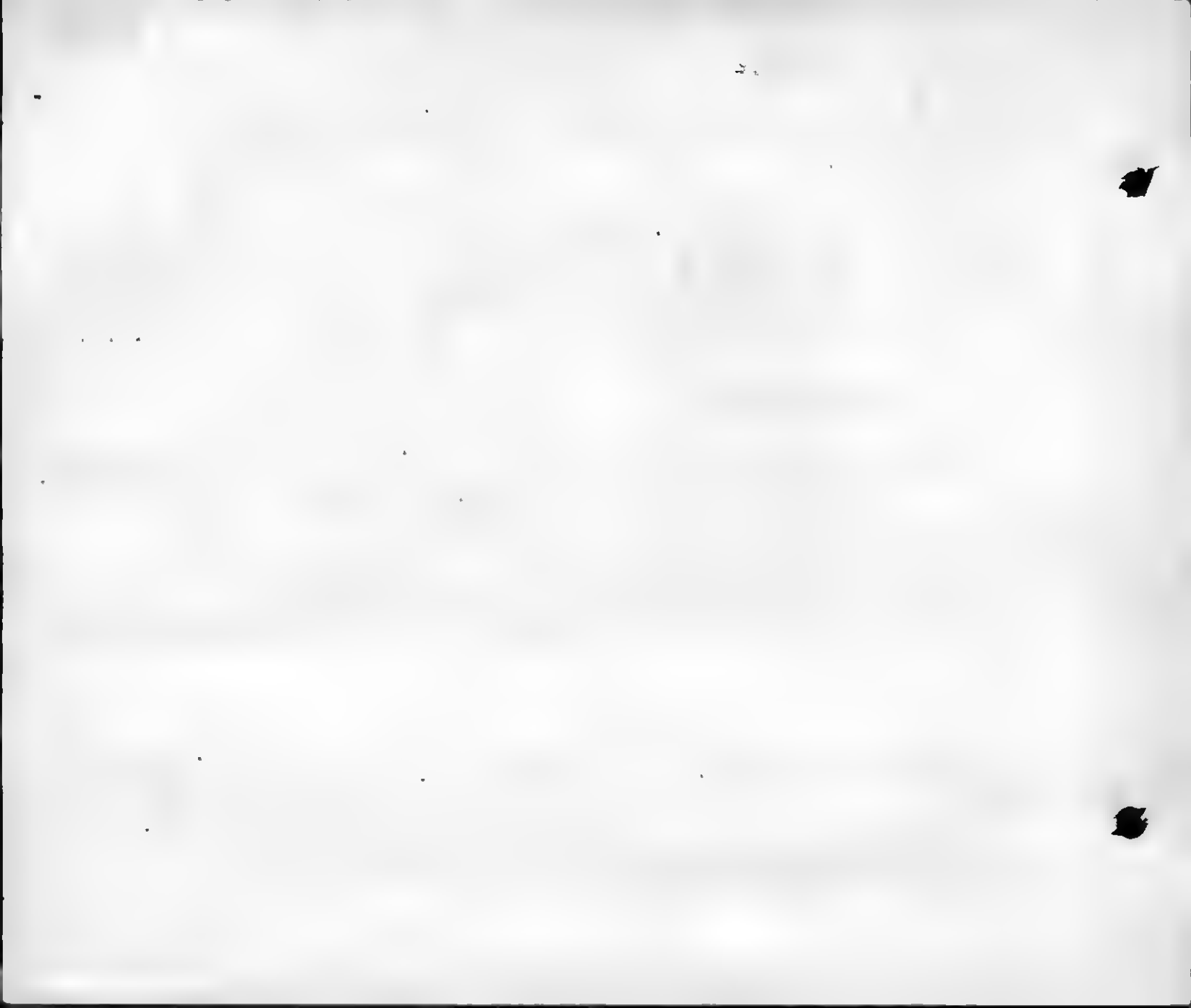
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Harford and Balt</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON MD.</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>Greenway and Falls Road</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN HOPPER HAINES</b>		4. DATE OF DEATH Month <b>OCT</b> Day <b>24</b> Year <b>59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 29 1875</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HASTINGS HAINES</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET KNIGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MOLLIE H. DOYLE</b> (D) Address <b>Greenway and Falls</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis, infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Has black right eye area (melanotic sarcoma) On Prstate 17 yrs ago</b>			
19. WAS AUTOPSY PERFORMED? <b>NO</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>No sign of injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 24 '59</b> 19 <b>8:25 PM</b> to death <b>8:30 PM</b> the deceased alive on <b>Oct 24th 8:25 PM</b> and that death occurred at <b>8:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>321 Dunkirk Rd Balto 1q Md.</b> DATE SIGNED <b>10/24 1959</b>			
ACTUAL SIGNATURE <b>Charles Victor Richards</b> M.D. <b>321 Dunkirk Rd Balto 1q Md.</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES VICTOR RICHARDS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 27, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Timonium, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc. Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Colin S. Kraus</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

11088

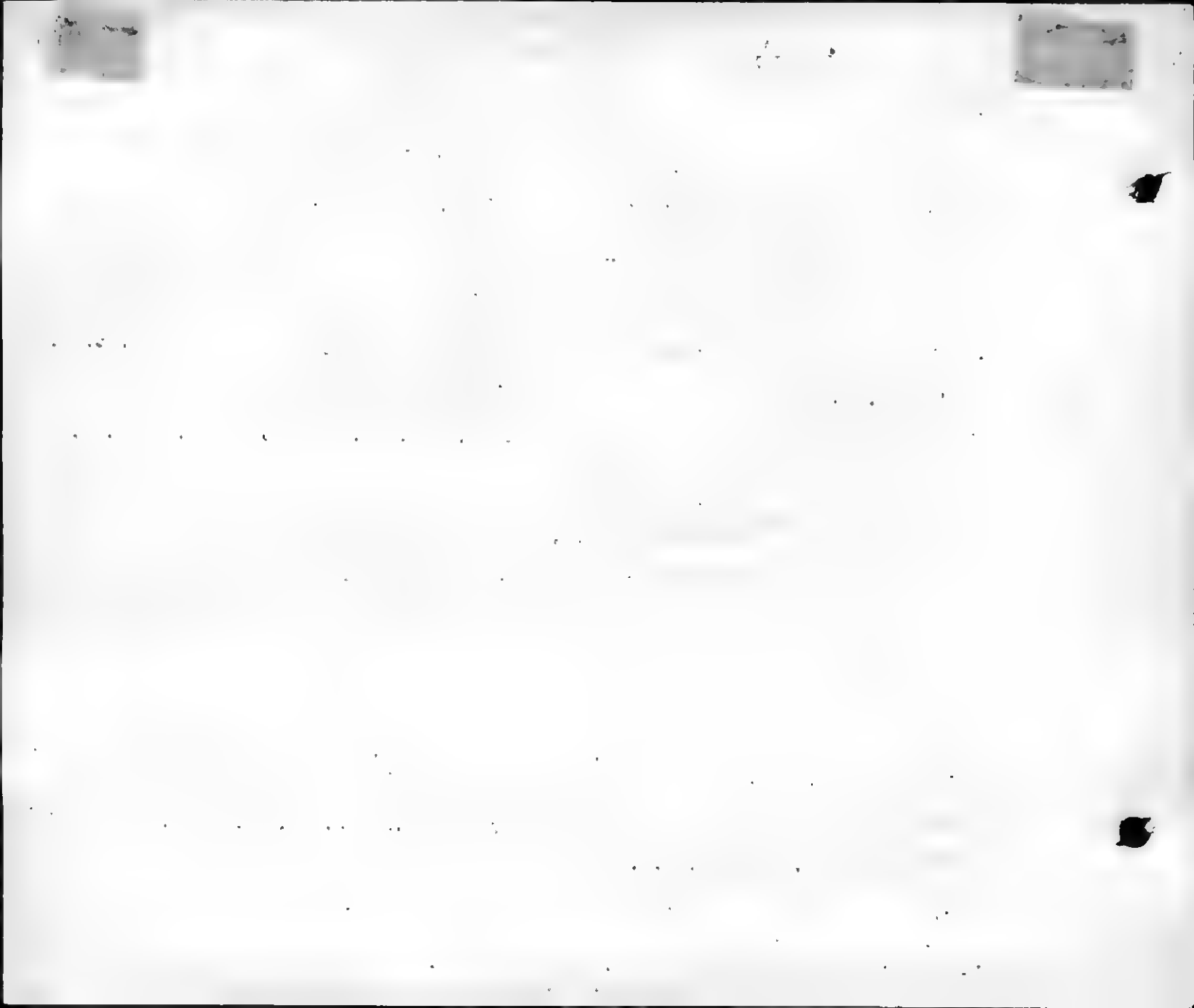
11056

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY	
c. LENGTH OF STAY IN lb <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>622 North Stockton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM --- HALL</b>		4. DATE OF DEATH Month Day Year <b>October 11 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/1895</b>	9. AGE (In years last birthday) yrs. <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>11 19 59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William H. Hall</b>		14. MOTHER'S MAIDEN NAME <b>Sarah H. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218 -05-5116</b>		INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Balto. 18, Md. Ft. Howard Division</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIABETES MELLITUS</b> <b>ENCEPHALOMALACIA, RIGHT INTERNAL CAPSUL AND PUTAMEN</b> <b>CHRONIC PASSIVE CONGESTION OF LUNG, LIVER &amp; INTESTINE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>RECENT</b> <b>RECENT</b>
21. I certify that I attended the deceased from <b>Oct. 6</b> , 19 <b>59</b> , to <b>Oct. 11</b> , 19 <b>59</b> , and that death occurred at <b>8:35 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD., FT. HOWARD, MD. 10/12/59</b> ACTUAL SIGNATURE <b>Harold R. Johnson</b> M.D. PHYSICIAN'S NAME (Type) <b>HAROLD R. JOHNSON, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Cooper</b>		24a. REC'D BY REGISTRAR <b>OCT 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Walter L. Brown</b>		24c. ADDRESS <b>512 N. Carrollton Ave. Balto. Md.</b>			

Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11089

## CERTIFICATE OF DEATH

Reg. Dist. No.

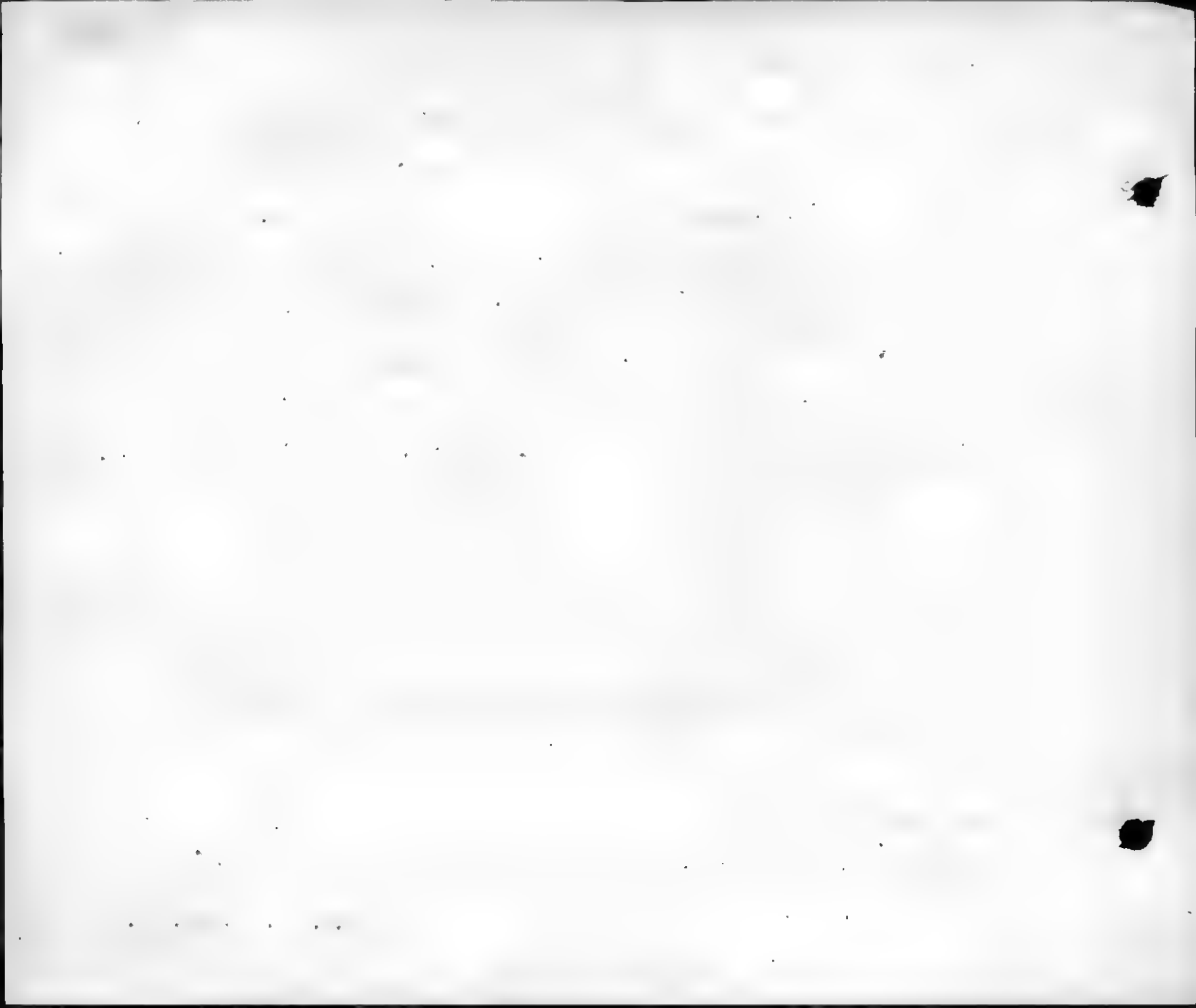
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in pines nursing home</u>				d. STREET ADDRESS <u>2909 Ritchie Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>B</u> Last <u>HAMMOND</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown Warren</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Shick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		INFORMANT <u>Mrs. Louise M. Walter</u>		Address <u>2909 Ritchie Ave. 19</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-25</u> , 19 <u>59</u> , to <u>10-4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-3</u> , 19 <u>59</u> , and that death occurred at <u>8:50</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6207 Frederick Ave. Baltimore, Md.</u> DATE SIGNED <u>10-5-59</u> SIGNATURE <u>Wilmer K. Gallagher</u> PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> <u>Baltimore-28 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>2401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles A. Huns</u>			

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

VS A15 (4)  
15M 9/58



11090

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b>		d. STREET ADDRESS <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>GUY</b>		First <b>GUY</b>		Middle <b>---</b>		Last <b>HANDLEY</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>2</b>		Year <b>1959</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 8, 1896</b>		9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months <b>63</b>		IF UNDER 24 HRS Hours <b>63</b>		Min. <b>63</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Mill</b>				11. BIRTHPLACE (State or foreign country) <b>Church Creek, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Fred K. Handley</b>						14. MOTHER'S MAIDEN NAME <b>Sara Meekins</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I</b>				INFORMANT <b>Clinical Records, VAH, Baltimore, Md. Ft. Howard/</b>				Address <b>Division</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>												<b>3 DAYS</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b>												<b>UNKNOWN</b>							
(c) <b>HYPERTROPHY AND DILATATION OF THE HEART</b>												<b>UNKNOWN</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September 29 1959</b> to <b>October 2 1959</b> and that death occurred at <b>3:10 A.M.</b> from the causes and on the date stated above.																			
ACTUAL SIGNATURE <i>John W. Crawford</i>												ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTO. 18, MD. FORT HOWARD DIV.</b>				DATE SIGNED <b>10/2/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-4-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Church Creek, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Thomas</i>												24a. REC'D BY REGISTRAR DATE <b>OCT 6 '59</b>				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>			
Kenneth R. Thomas Funeral Home, Cambridge, Md.																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

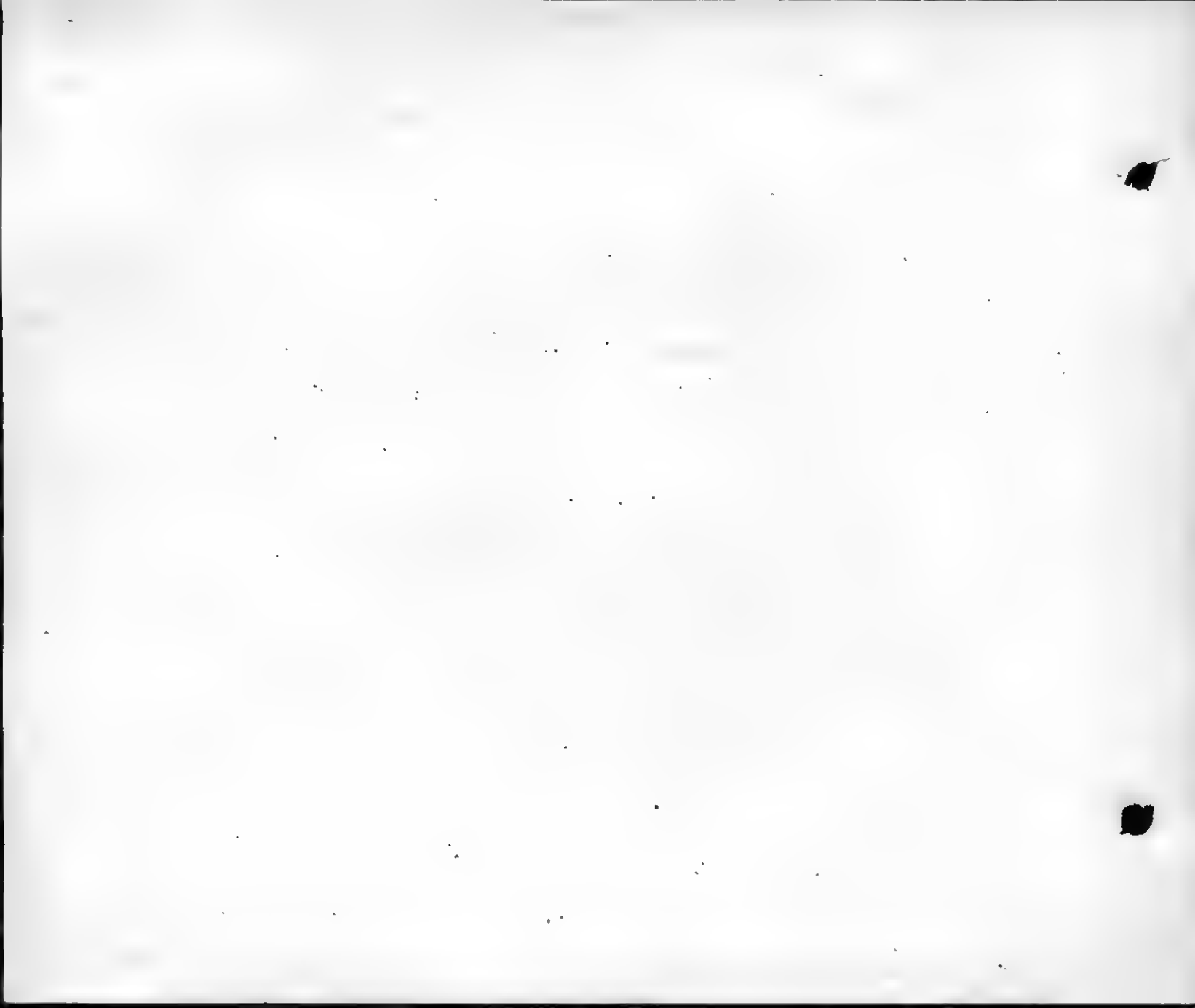
CERTIFICATE OF DEATH

Reg. Dist. No.

11059

11091

1 PLACE OF DEATH a. COUNTY <i>Balto.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>22 Wade Ave.</i>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> d. STREET ADDRESS <i>22 Wade Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Jerry David Hardy</i> First Middle Last 4. DATE OF DEATH <i>Oct. 6</i> Month Day Year <i>1959</i>		5. SEX <i>White male</i> 6. COLOR OR RACE <i>White male</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>11/9/94</i> 9. AGE (In years last birthday) <i>64</i> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Asst. Pharm. Spring Grove Hosp.</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>N.C.</i> 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Benjamin Hardy</i> 14. MOTHER'S MAIDEN NAME <i>Rigdon</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <i>000-000-000</i> 17. INFORMANT <i>Mrs. Eurath Hardy</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 4-11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arteriosclerotic heart disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>4 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>1955</i> , 19, to <i>Oct 6</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Oct. 4</i> , 19 <i>59</i> , and that death occurred at <i>7:20 P.M.</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>John A. Nesbitt Jr.</i> M.D. <i>1118 St. Paul St.</i> DATE SIGNED <i>10-7-59</i>		PHYSICIAN'S NAME (Type) <i>John A. Nesbitt Jr.</i> <i>Baltimore 2, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>10/9/59</i> 22c. NAME OF CEMETERY OR CREMATORY <i>M.E. Church</i> 22d. LOCATION (City, town, or county) (State) <i>Dumbarton, Carroll Co. Md.</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 9 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIVUM</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X TIMONIVUM</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>YORK ROAD</b>				d. STREET ADDRESS <b>OAKWAY ROAD</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>A.</b> Last <b>HAULPLIPE</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1889</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer - Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A. Haulplipe</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Gordon</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FAMILY RECORDS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Conclusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CEMETERY</b>			
22d. LOCATION (City, town, or county) (State) <b>TEXAS, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 30 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Md.</b> ADDRESS							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

**10/25/59**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11093

CERTIFICATE OF DEATH

Reg. Dist. No.

11061

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Parkton</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>RONALD</b> Last <b>HEAPS</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>14,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	11. BIRTHPLACE (State or foreign country) <b>Harford Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>David Heaps</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth King</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>218-14-9832</b>		17. INFORMANT Address <b>Mrs. Grace A. Heaps, Parkton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic C-V disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1926</b> to <b>10/14/59</b> , that I last saw the deceased alive on <b>10/14/59</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>A. M. France</b>		ADDRESS (Street, city or town, state) <b>PARKTON, Md</b> DATE SIGNED <b>10/15/59</b>	
PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>OCT. 17, 1959</b>	<b>Ayres Chapel</b>	<b>Norrisville, Harford Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewartstown, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 200 10-15-59 et

## CERTIFICATE OF DEATH

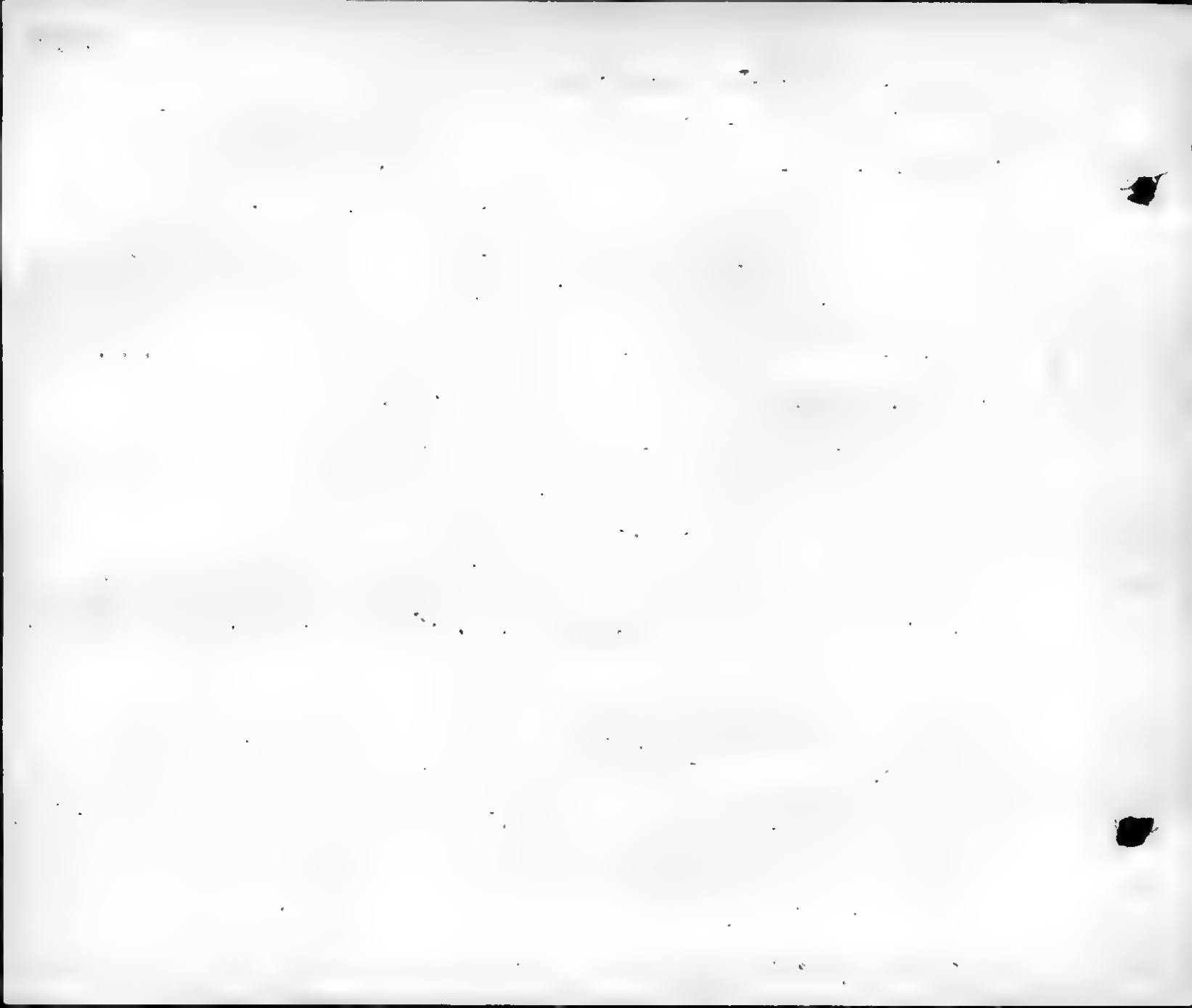
Reg. Dist. No.

11062

11094

1. PLACE OF DEATH <b>Rosewood State Training School</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)			
a. COUNTY <b>Baltimore</b>		MARYLAND		a. STATE <b>Maryland</b>		b. COUNTY <b>City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN 1b <b>3 Mos. 9 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 13, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>2506 East Preston Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Francis</b> Last <b>Herbert</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/45</b>		9. AGE (In years last birthday) <b>13</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis E. Herbert</b>				14. MOTHER'S MAIDEN NAME <b>Anna Herbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>		INFORMANT <b>Rosewood Records</b>		Address <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>715X</b> DUE TO <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Decubitus over the sacrum &amp; both hips</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Tuberous sclerosis with hypothalamic invol.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b>		(County), (State)	
21. I certify that I attended the deceased from <b>6/25</b> 19 <b>59</b> to <b>10/4</b> 19 <b>59</b> that I lost saw the deceased alive on <b>10/4</b> 19 <b>59</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest J. Dehn</b>				ADDRESS (Street, city or town, state) <b>Rosewood Lane, Owings Mills, Md.</b>			
PHYSICIAN'S NAME (Type) <b>—</b>				DATE SIGNED <b>10/4/59</b>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		22d. LOCAT ON (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Inc.</b> ADDRESS <b>2431-35 E. Oliver St.</b>				24a. REC'D BY REGISTRAR <b>8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Walter E. Hines</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be relayed to the hospital or attending physician by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11095

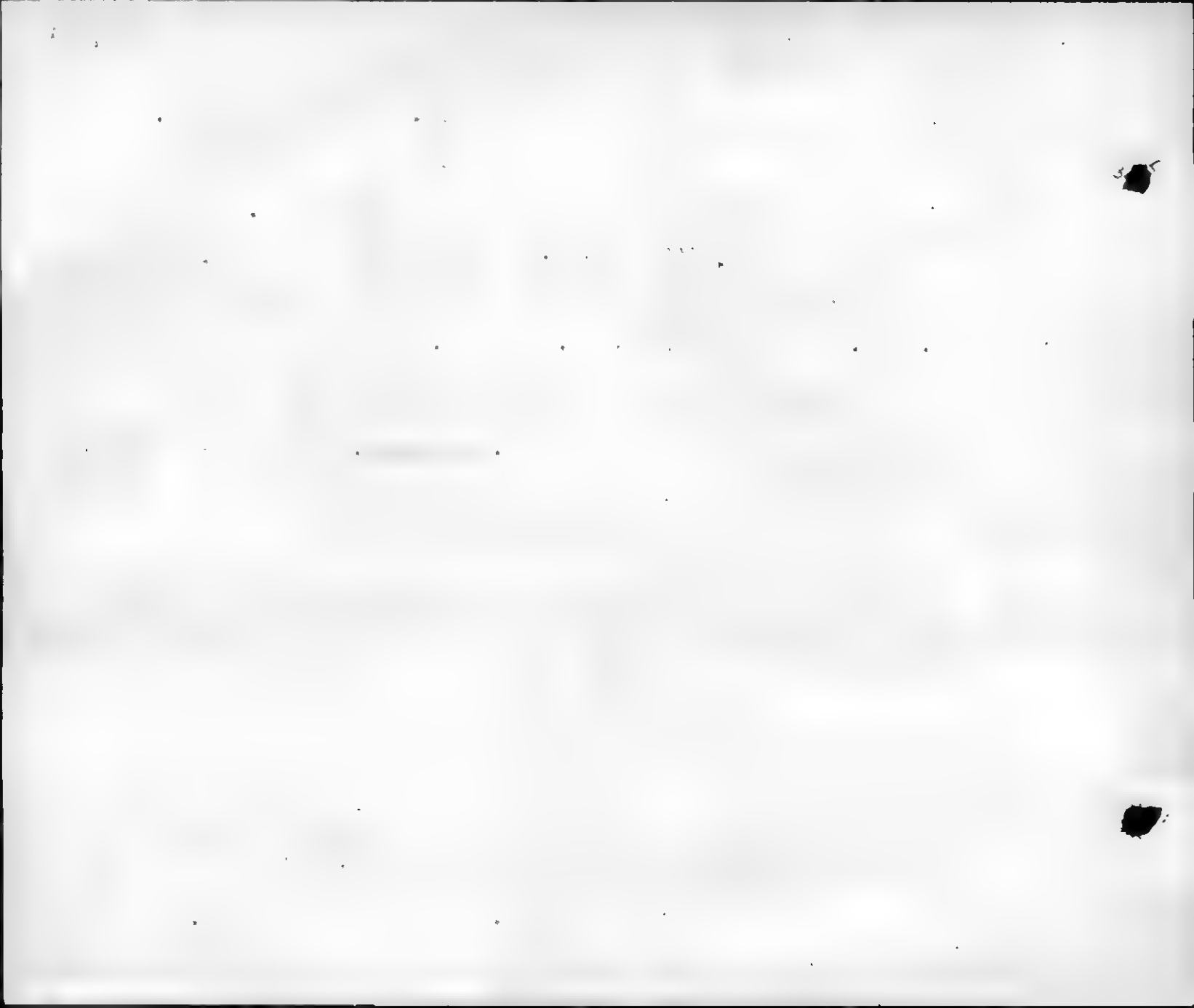
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
c. LENGTH OF STAY IN 1b <u>74r 2 mo 2 day X</u>		d. STREET ADDRESS <u>300 Seminary Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carl G. M. Hilgenberg</u>		4. DATE OF DEATH <u>Oct. 6, 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS	11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Md. Exec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Mfg.</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Mr. Charles Hilgenberg</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Johanne Lertz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Lutherville</u>	
17. <u>Mrs. Angelica R. Hilgenberg - 300 Seminary Av</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Arteriosclerosis</u> (c) <u>331X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>36</u> , to <u>Oct 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 4</u> , 19 <u>59</u> , and that death occurred at <u>11 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Parsons</u> M.D.		ADDRESS (Street, city or town, state) <u>11 E. Chase St Baltimore 2</u>	
PHYSICIAN'S NAME (Type) <u>John W. Parsons</u>		DATE SIGNED <u>Oct 13 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Lattimer &amp; Sons - Baltimore Md</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11011

## CERTIFICATE OF DEATH

11064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Dundalk</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6817 Fifth Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Hlopak, Sr.</u> Last <u>Hlopak, Sr.</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>9</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1879</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sp Point</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Joseph Hlopak</u>		14. MOTHER'S MAIDEN NAME <u>Maria Vitkovits</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-5529</u>	
17. INFORMANT <u>Rose M Litrenta</u>		Address <u>6817 Fifth Ave. Dundalk</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Heart Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Heart Insufficiency</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1</u> to <u>10-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-1</u> , 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Belt 22 m</u> DATE SIGNED <u>10-10-59</u>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. <u>2 Hlopak</u>	
PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Dabrowski</u>		ADDRESS <u>1001 A Dundalk Ave</u>	
24a. REC'D BY REGISTRAR <u>Oct 14 59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hlopak</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

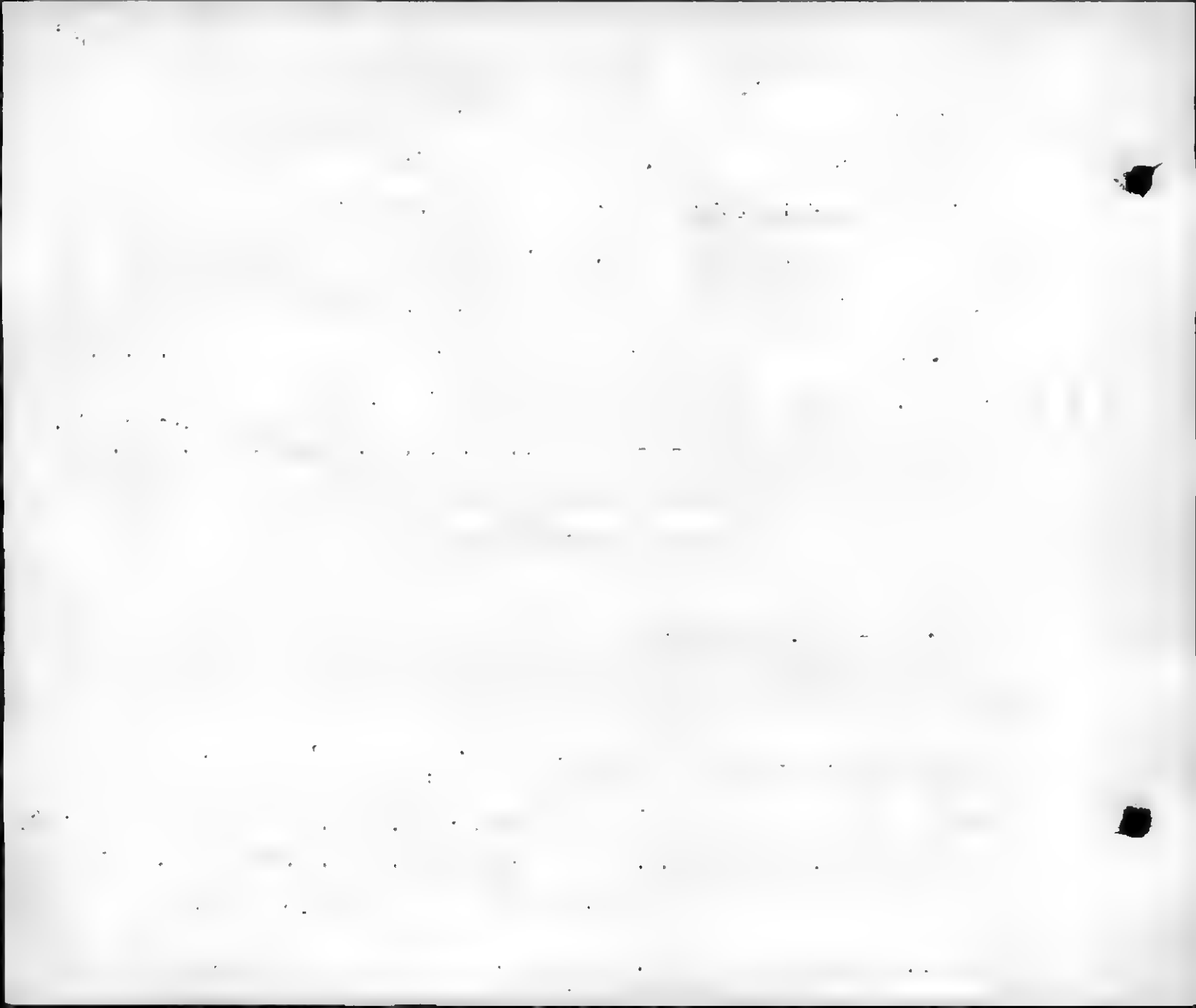
12013

11096

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>74 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>204 E. Barney Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>HOLZNER</b>			4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 1, 1894</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Cab</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Henry A. Holzner</b>		
14. MOTHER'S MAIDEN NAME <b>Catherine E. Hubbard</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>440 W. W. I.</b>		
16. SOCIAL SECURITY NO. <b>217-18-6528</b>			INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Balto, 18, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Cerebrovascular Accident</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia - 48 Hours duration</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b>  <b>UNKNOWN</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o m. _____ p. m. _____ 19 _____		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		
20f. (City or town) _____ (County) _____ (State) _____			21. I certify that I attended the deceased from <b>August 6, 1959</b> , to <b>October 19, 1959</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>John W. Crawford</b>			ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</b>		
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>			DATE SIGNED <b>10/19/59</b>		
22a. BLUR AL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>10/22/59</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred A. Krause and Son</b>			ADDRESS <b>1216 S. Charles St. Baltimore, Md.</b>		
24a. REC'D BY REGISTRAR <b>Oct 23 '59</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11065

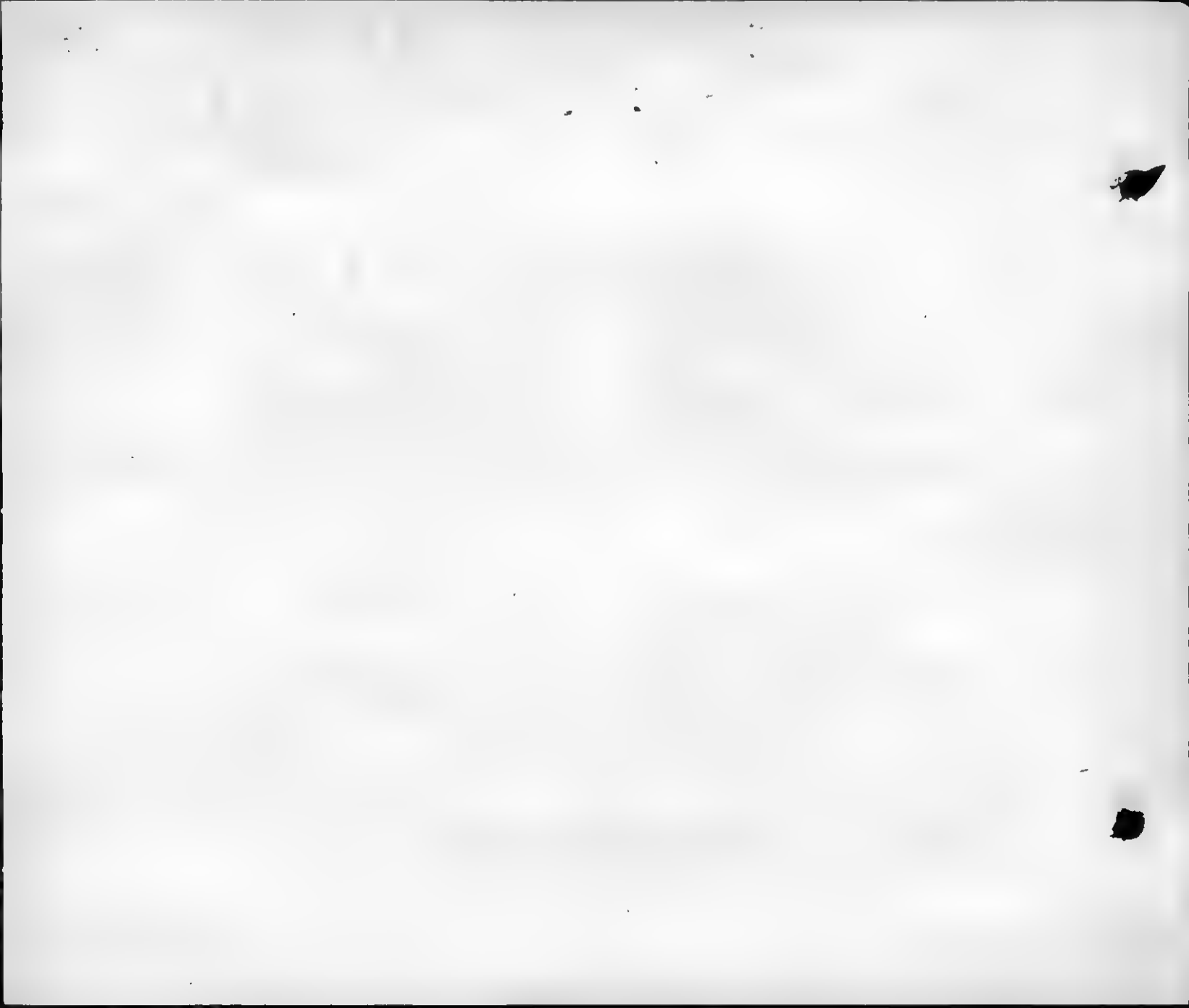
11097

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>BALTIMORE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>enroute to hospital</u>				d. STREET ADDRESS <u>2 Walnut ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>EDWIN</u> Middle <u>HOOD</u> Last				4. DATE OF DEATH <u>October</u> Month <u>12</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector - Rural State Police Comm.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Chatham Hood</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Maude Hood - Sykesville, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO <u>E PULMONARY EDEMA -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC CONG. HEART FAILURE -</u> (c) <u>1 DAY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 YEARS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1</u> , 19 <u>50</u> , to <u>OCT 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 12</u> , 19 <u>59</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D.				ADDRESS (Street, city or town, state) <u>3601 CHEFMAR RD - BALTO - 7 - MD</u> DATE SIGNED <u>10/12/59</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				<u>BALTO - 7 - MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT View</u>		22d. LOCATION (City, town, or county) (State) <u>Alpha, Howard Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hight Sykesville, MD</u> ADDRESS				24a. REC'D BY REGISTRAR <u>OCT 19 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11098

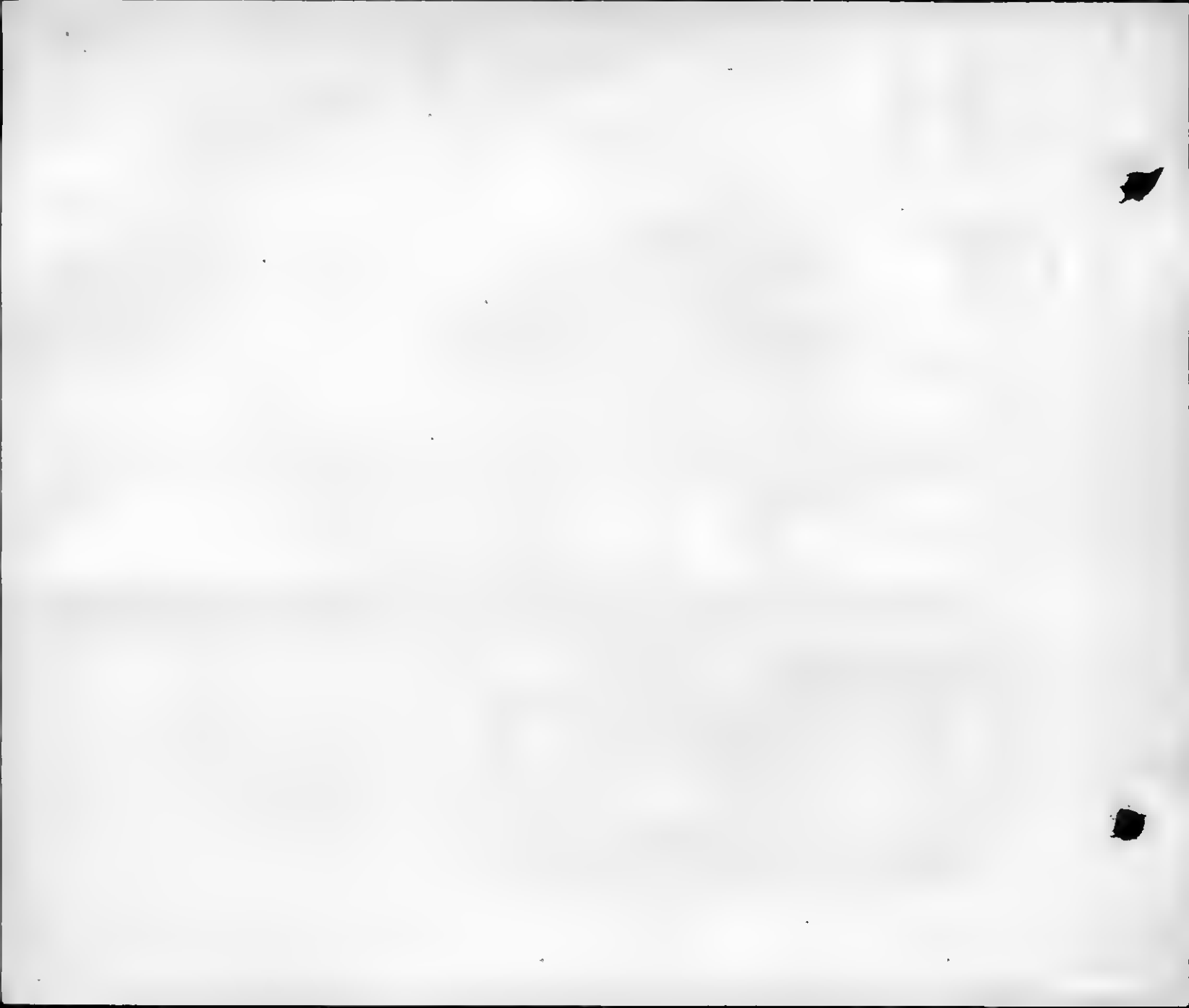
## CERTIFICATE OF DEATH

11066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>3yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Berrymans Lane</b>		e. STREET ADDRESS <b>Berrymans Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Harley Kemp Horner</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1908</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>19</b> Hours <b>59</b>	11. IF UNDER 24 HRS Months <b>51</b> Days <b>19</b> Hours <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Koppers Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward Baker Horner</b>		14. MOTHER'S MAIDEN NAME <b>Eva Kemp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>218-07-4926</b>	
17. INFORMANT <b>Mrs. Mindell E. Horner</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>45 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 4, 1959</b> to <b>October 15, 1959</b> , that I last saw the deceased alive on <b>October 12, 1959</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Carroll E. McWilliams</b>		DATE SIGNED <b>October 15, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Reisterstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11099

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

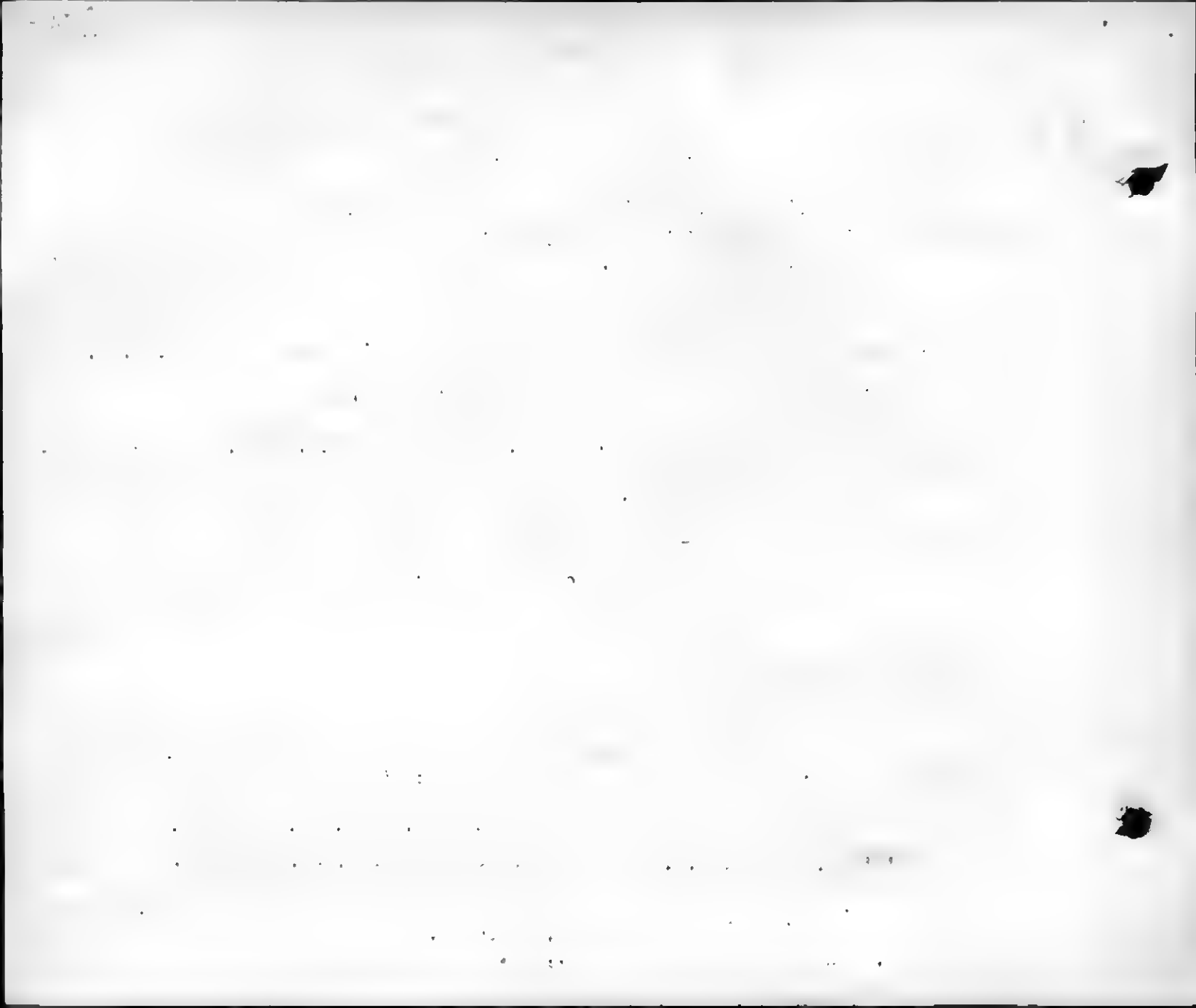
Reg. Dist. No.

11067

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>52 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as: First <b>JOHNNIE</b> Middle (NMI) <b>HUDNALL</b> ) (Type or print) <b>JOHN H. HUDNALL</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1892</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Silas Hudnall</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Dunway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-01-1844</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>2040</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>BONE-MARROW APLASIA</b> DUE TO (c) <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 25, 1959</b> to <b>October 16, 1959</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel A. Nieves</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>DANIEL A. NIEVES, M.D.</b>		<b>VAH, BALTO 18, MD. FT. HOWARD MD. 10/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>10/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Private</b>	22d. LOCATION (City, town, or county) (State) <b>Northumberland County, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips Funeral Balto., Md.</b>		24. REGISTRAR'S SIGNATURE <b>REC'D BY REGISTRAR DATE OCT 21 59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



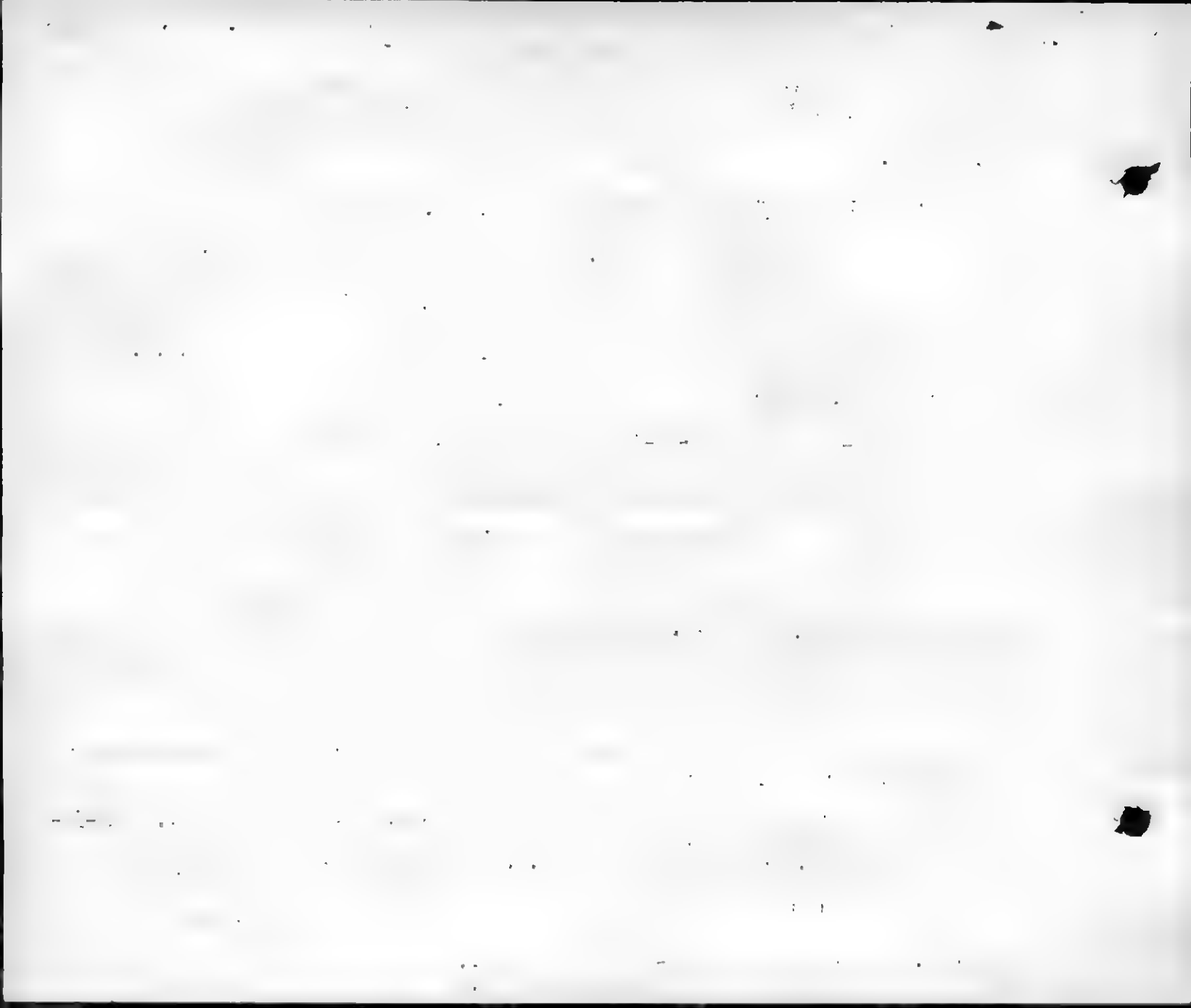
11100

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>816 St. Paul Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>J.</b> Last <b>HUMMEL</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 27, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK STATE</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK J. HUMMEL</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE YOUNG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>220-24-2340</b>	
INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ARTERIOSCLEROTIC HEART DISEASE WITH VENTRICULAR TACHYCARDIA</b> (b) <b>TACHYCARDIA</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL HRS</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS - Duration Unknown</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 29, 1959</b> , to <b>October 30, 1959</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Balto Md- Ft Howard Div.</b> DATE SIGNED <b>10-30-59</b>			
ACTUAL SIGNATURE <b>Walter J. Pijanowski</b>		M.D. <b>VAH Balto Md - Ft Howard Division</b>	
PHYSICIAN'S NAME (Type) <b>Walter J. Pijanowski</b>		M.D. <b>VAH Balto Md - Ft Howard Division</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11 '3 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
ADDRESS <b>Howard H. Hubbard Funeral Home-4107 Wilkins Ave. Baltimore 29, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11069

Reg. Dist. No.

11101

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11138 Reisterstown Road</b>		e. STREET ADDRESS <b>11138 Reisterstown Road</b>	
3. NAME OF DECEASED (Type or print) <b>Susan Adele Hunt</b>		4. DATE OF DEATH <b>Oct 6, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13. FATHER'S NAME <b>Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Jacob B. Hunt, Owings Mills, Md.</b>		18. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic C-V Disease</b> (c), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Barbiturate Depression, Mental Depression</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>10-8-59</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 9, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home, 3631 Falls Rd. Balto</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles P. Burgee</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

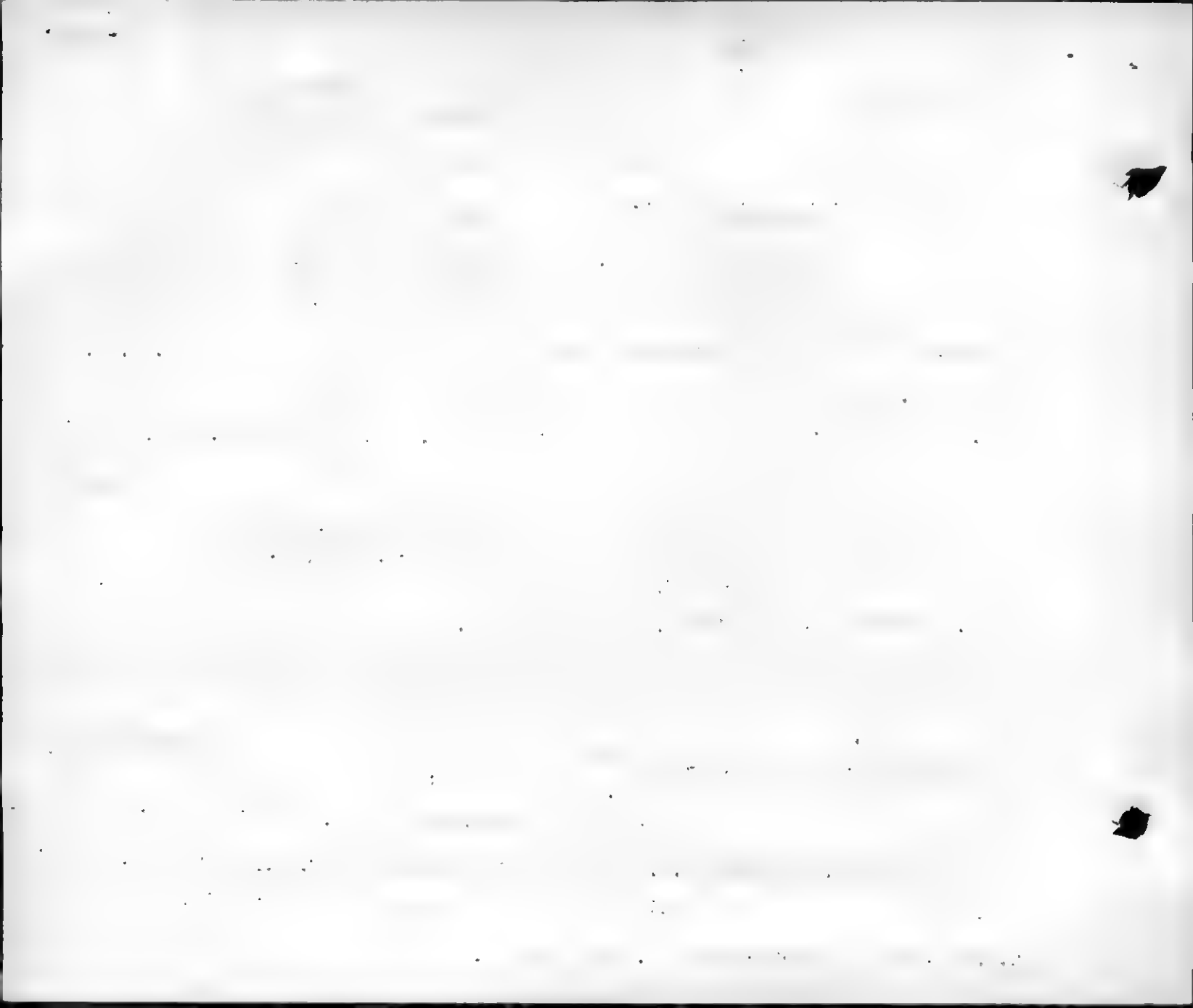
**11102**

**CERTIFICATE OF DEATH**

Reg. Dist. No.

**11070**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>21 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Route 1, Box 282</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>LESTER</b> Middle <b>L.</b> Last <b>JACKSON</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1895</b>	9. AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing Company</b>		11. BIRTHPLACE (State or foreign country) <b>Mayo, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Leander C. Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude M. Cummings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO.		INFORMANT <b>Clinical Rec., VAH, Baltimore, Md. Fort Howard/</b>		Address <b>Division</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF THE PROSTATE WITH INVASION INTO THE URINARY BLADDER AND METASTASIS TO PERITONEUM, OMENTUM, LIVER AND LUNGS</b> (c) <b>OLD FIBROUS CALCIFIC NODULE, APEX RIGHT LUNG.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>2 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD FIBROUS CALCIFIC NODULE, APEX RIGHT LUNG.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>September 10, 1959</b> to <b>October 1, 1959</b> and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, BALTO, 18, MD. FORT HOWARD DIVISION 10/2/59</b>		DATE SIGNED <b>10/2/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, BALTIMORE, MD. FT. HOWARD DIVISION</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>OCT-6 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B.L. Hopping</b>		ADDRESS <b>West St., Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>	



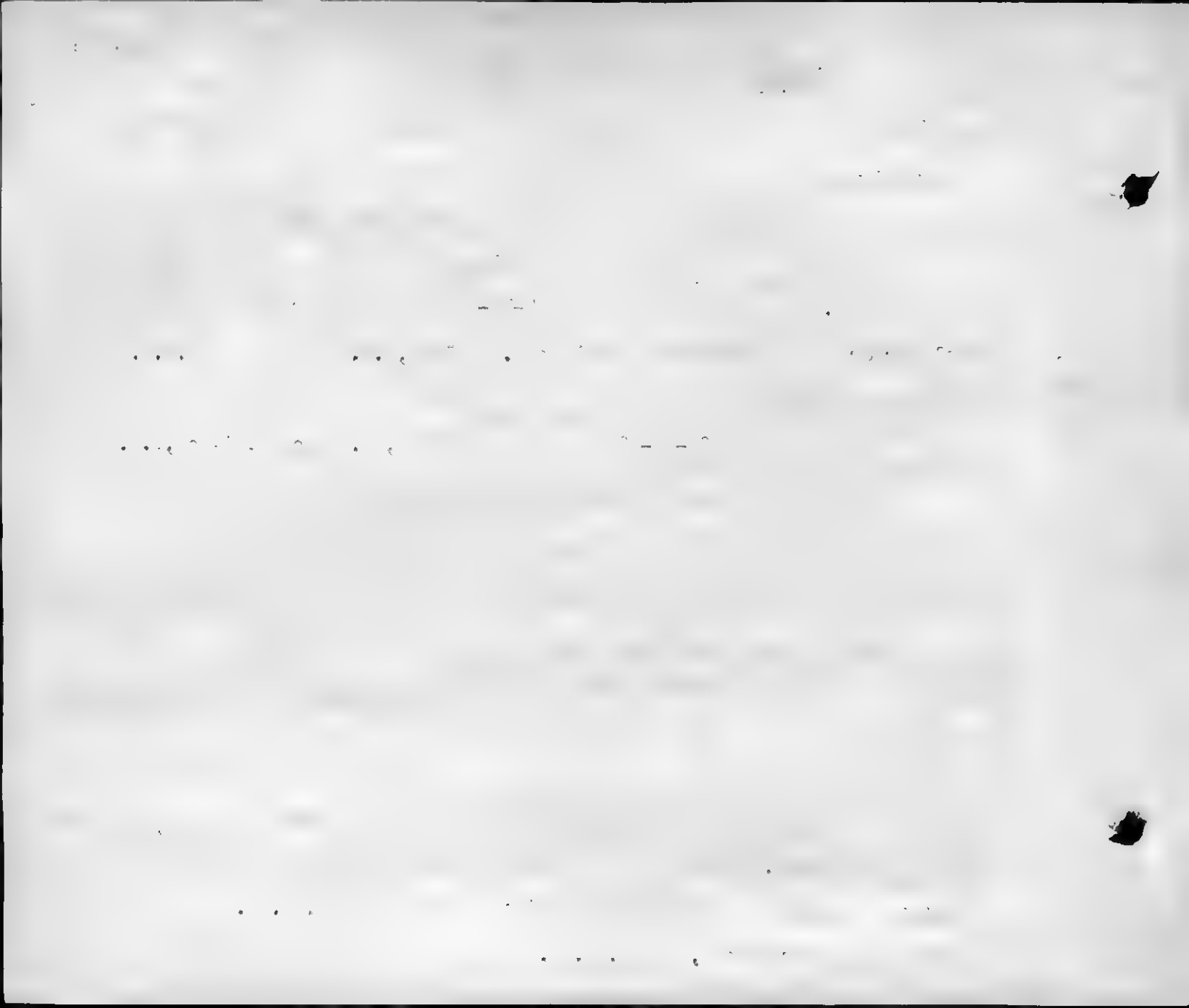
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
11012		Item 9		11012		11012		11071	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN b. <b>3 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>201 Clinton Lane</b>				
3. NAME OF DECEASED (Type or print) <b>Andrew</b> First Middle Last 4. DATE OF DEATH <b>October 24 1959</b> Month Day Year					5. SEX <b>Male</b> 6. COLOR OR RACE <b>C.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>7-19-32</b> 9. AGE (In years last birthday) <b>27</b> yrs. <b>26</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Corp. Milton, N.C.</b> 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <b>Danner Jeffreys</b> 14. MOTHER'S MAIDEN NAME <b>Maude</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>230-34-6380</b> 17. INFORMANT <b>Maude Jeffreys, Rt. #1, Box 7, Milton, N.C.</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wounds of chest and abdomen</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation</b> 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>10/29/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Baptist</b> 22d. LOCATION (City, town, or country) (State) <b>Milton, N. C.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/25/59</b> Address (Street, city, town, or county)				
23. FUNERAL DIRECTOR <b>Huco Plenty Funeral Home, Milton, N. C.</b> ADDRESS					24a. REC'D BY REGISTRAR <b>Oct 27 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>				



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11103

## CERTIFICATE OF DEATH

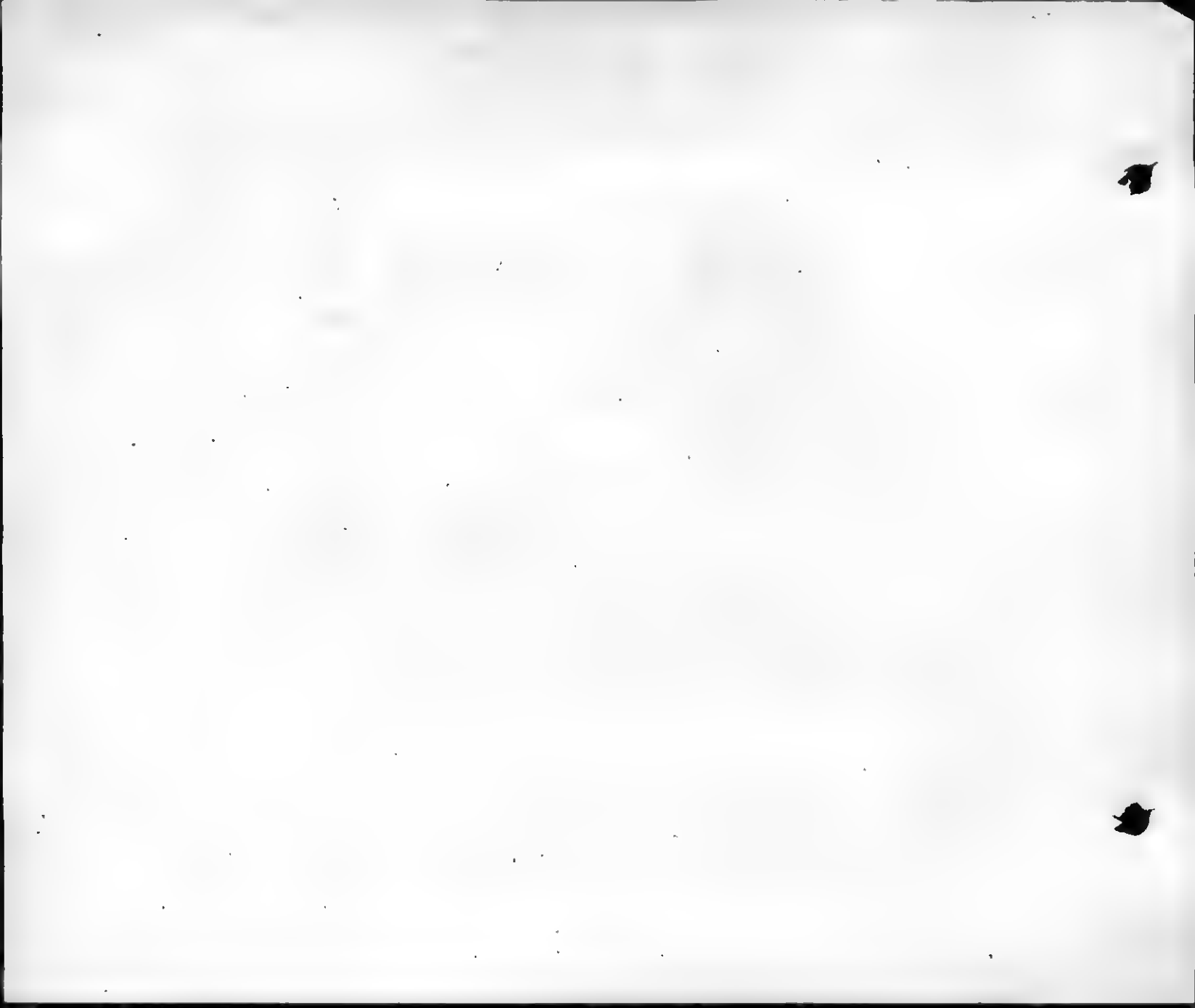
11072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>403 UPLAND Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles A. JERRENTRUPP</u>		4. DATE OF DEATH Month Day Year <u>10-14 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-98</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Rep. Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William JERRENTRUPP</u>		14. MOTHER'S MAIDEN NAME <u>MARY HOFFMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>FAMILY</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive &amp; Atherosclerotic Heart Disease</u> DUE TO (c) <u>3-4 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 22 1955</u> to <u>10/14 1959</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius C. Gluck, M.D.</u>		DATE SIGNED <u>10/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Julius C. Gluck, M.D.</u>		<u>Baltimore, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO., MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Cully Funeral Homes 130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3. Page 5 may be retained for your files.  
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VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

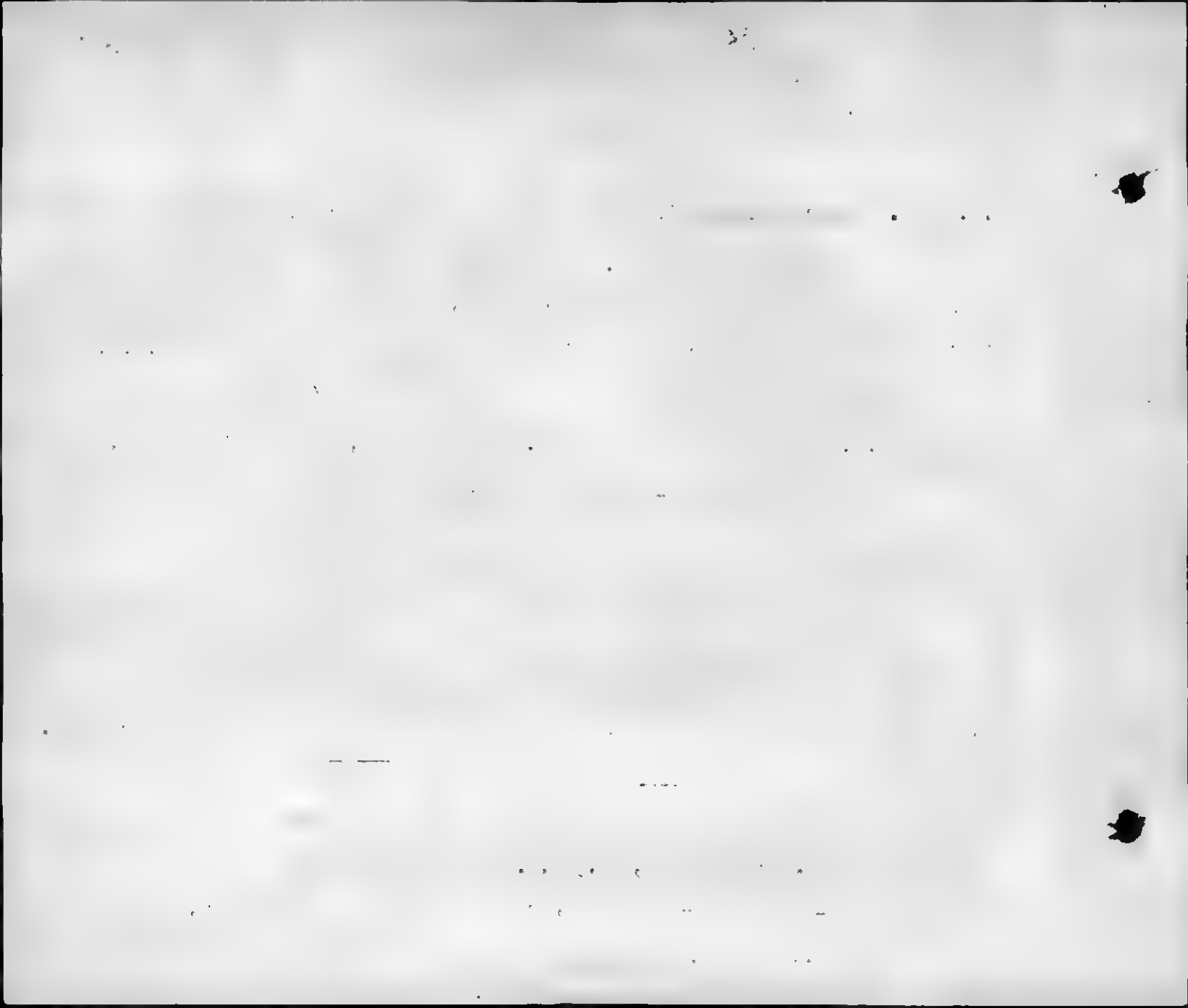
11104

11073

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admittance) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S.40 nr. Chesaco intersection</b>				d. STREET ADDRESS <b>5446 Narcissus Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>ERNEST T. JOHNSON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1920</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deck Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		9. AGE (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS. <b>39</b> yrs. Months Days Hours Min.	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>(unknown) Johnson</b>			
14. MOTHER'S MAIDEN NAME <b>Anna (unknown)</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>W.W.II</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Rosel Johnson, 5446 Narcissus Ave, ZONE 15</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt-force head injury</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto-truck collision</b>			
20c. TIME OF INJURY Month, Day, Year <b>10:55</b> <b>10/29</b> <b>1959</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>				20f. (City or town) (County) (State) <b>Baltimore Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. Bradley King, Jr.</i>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>11-2-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Entombment Lorraine Mausoleum,</b>				22d. LOCATION (City, town, or country) (State) <b>Woodlawn, Md</b>			
23. FUNERAL DIRECTOR <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR <b>NOV 3 59</b>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur D. Hana</i>			

MEDICAL CERTIFICATION

DATE SIGNED  
**10/30/59**





11105  
CERTIFICATE OF DEATH

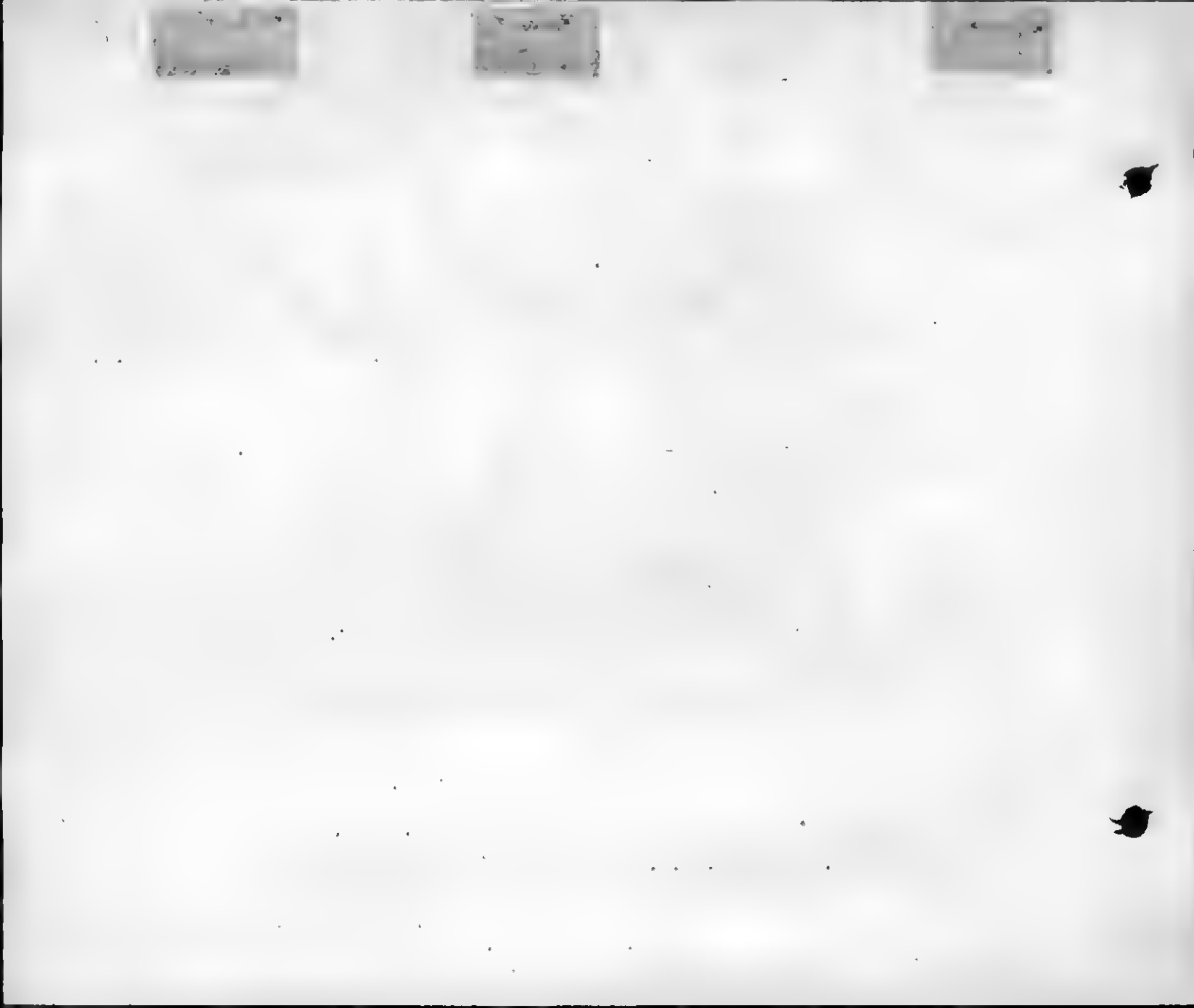
11074

Reg. Dist. No.

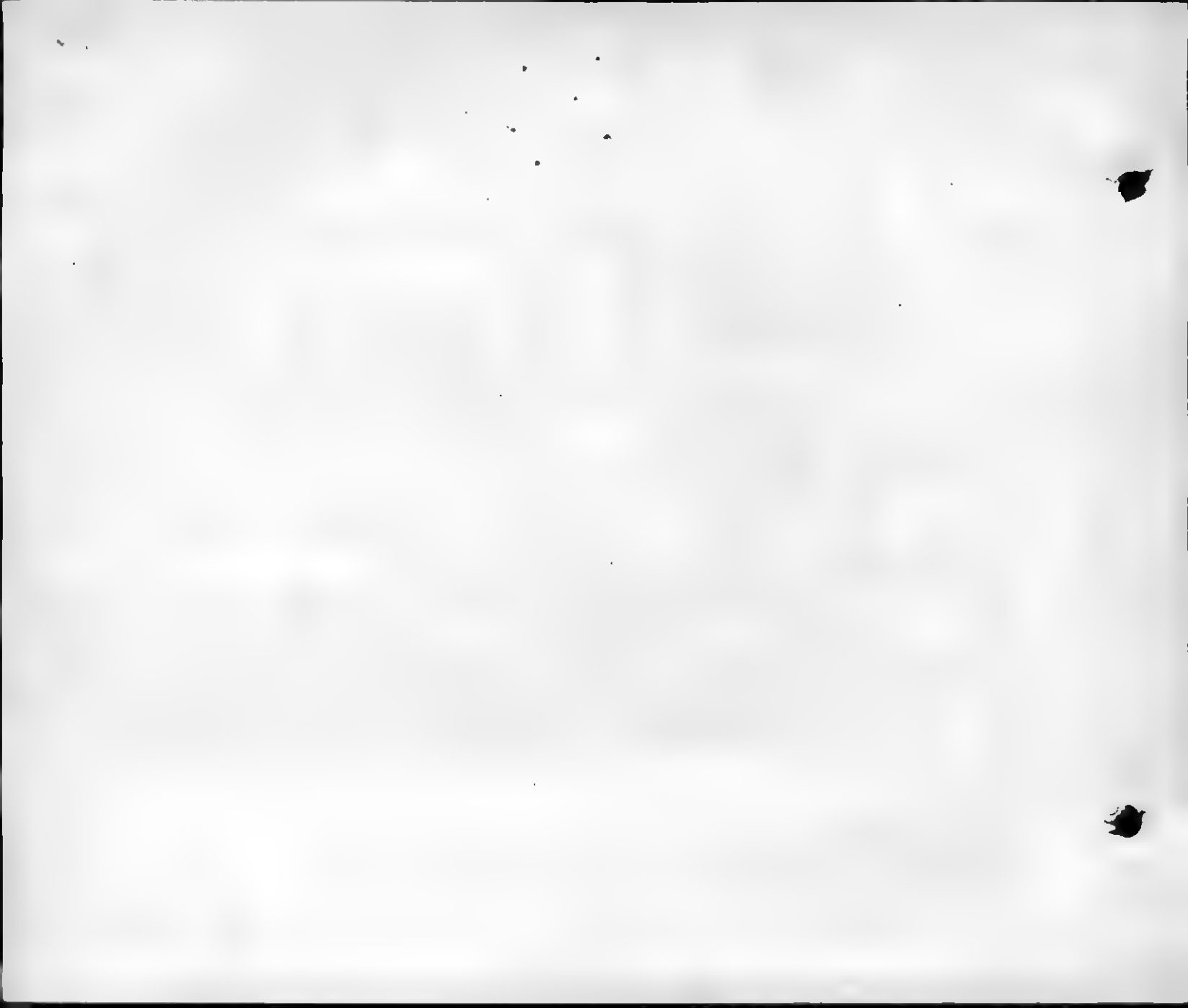
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>67 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE (17)</b>	
f. STREET ADDRESS <b>1704 LAURENS STREET</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH M. JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 15 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1877</b>
9. AGE (In years last birthday) <b>82 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Josiah Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Pratt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES 12/27/98-1-7-99</b>		16. SOCIAL SECURITY NO. <b>212-09-1442</b>	
17. INFORMANT <b>Clinical Records, Balto. 18, Md. Fort Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ABSCESS OF LIVER, RIGHT LOBE</b> <b>EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MARKED EMPHYSEMA OF LUNGS, OLD</b> <b>ARTERIOSCLEROSIS, GENERALIZED</b> (c) <b>ARTERIOSCLEROSIS OF PULMONARY ARTERY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic passive congestion of lungs, liver and intestines.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 9, 1959</b> to <b>October 15, 1959</b> and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION 10/16/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>FORT HOWARD DIVISION</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Kelson</b>		24a. REC'D BY REGISTRAR <b>OCT 19 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## CERTIFICATE OF DEATH

11076

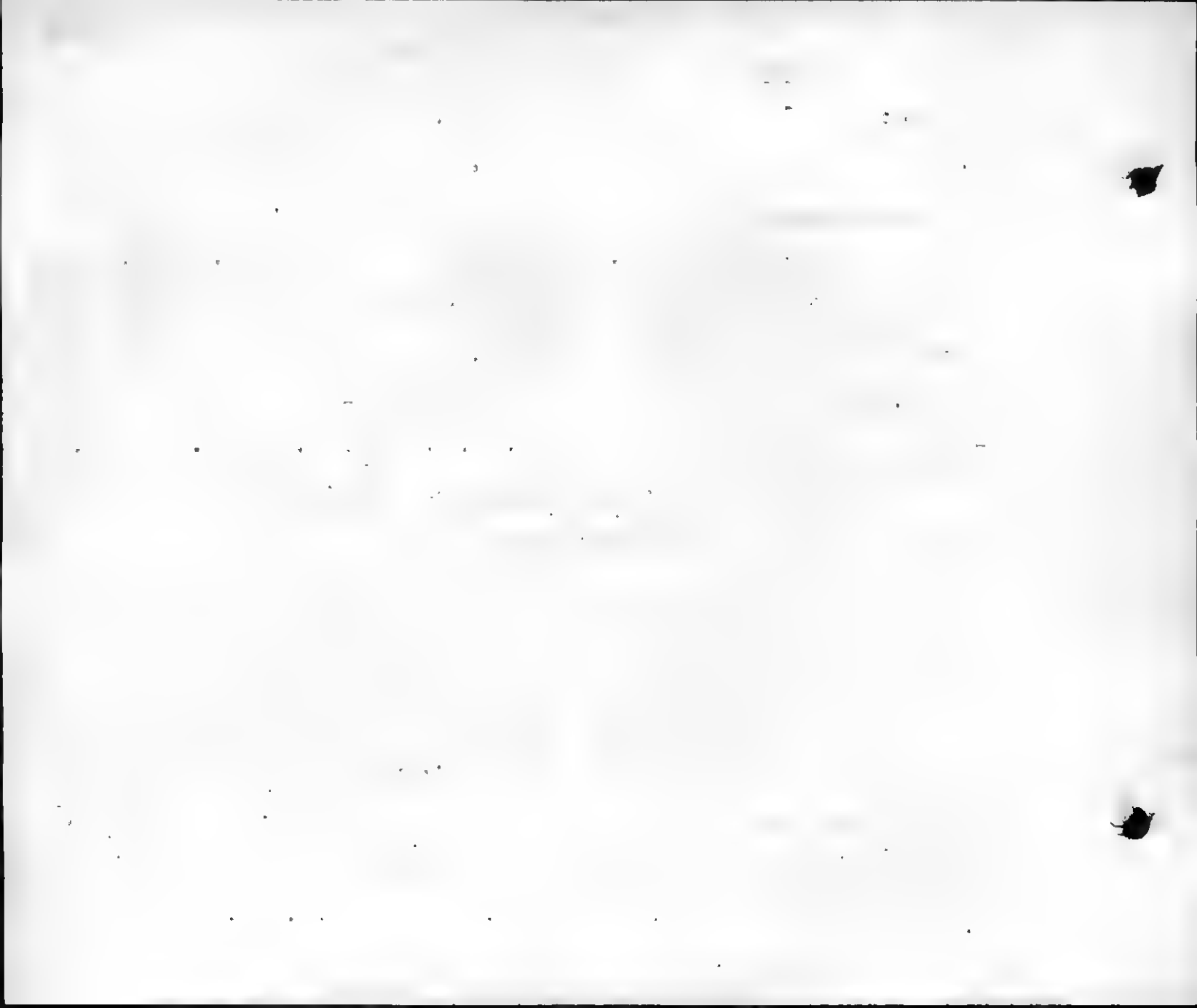
Reg. Dist. No.

11107

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ( <b>Holly Hill Manor</b> ) <b>531 Stevenson Lane</b>				d. STREET ADDRESS <b>4710 Kernwood Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>IRENE</b> Middle <b>M.</b> Last <b>KELLER</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1886</b>		9. AGE (In years last birthday) <b>73</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry C. Allano</b>				14. MOTHER'S MAIDEN NAME <b>Adelia —</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		INFORMANT <b>Mrs. Wm. S. Pirie, Jr.</b>		Address <b>231 Register Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>72X</b> DUE TO <b>Chronic Glomerular Nephritis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 10, 1959</b> to <b>Oct 20, 1959</b> that I last saw the deceased alive on <b>Oct 20, 1959</b> and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Laurence C. Post</b>		M.D. <b>6805 York Rd.</b>		ADDRESS (Street, city or town, state) <b>Baltimore</b>		DATE SIGNED <b>10/21/59</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>		<b>Baltimore</b>		<b>12</b>		<b>Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sam J. Lukens - Balt 17</b>				24a. REC'D BY REGISTRAR <b>OCT 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## INSTRUCTIONS

**THE ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

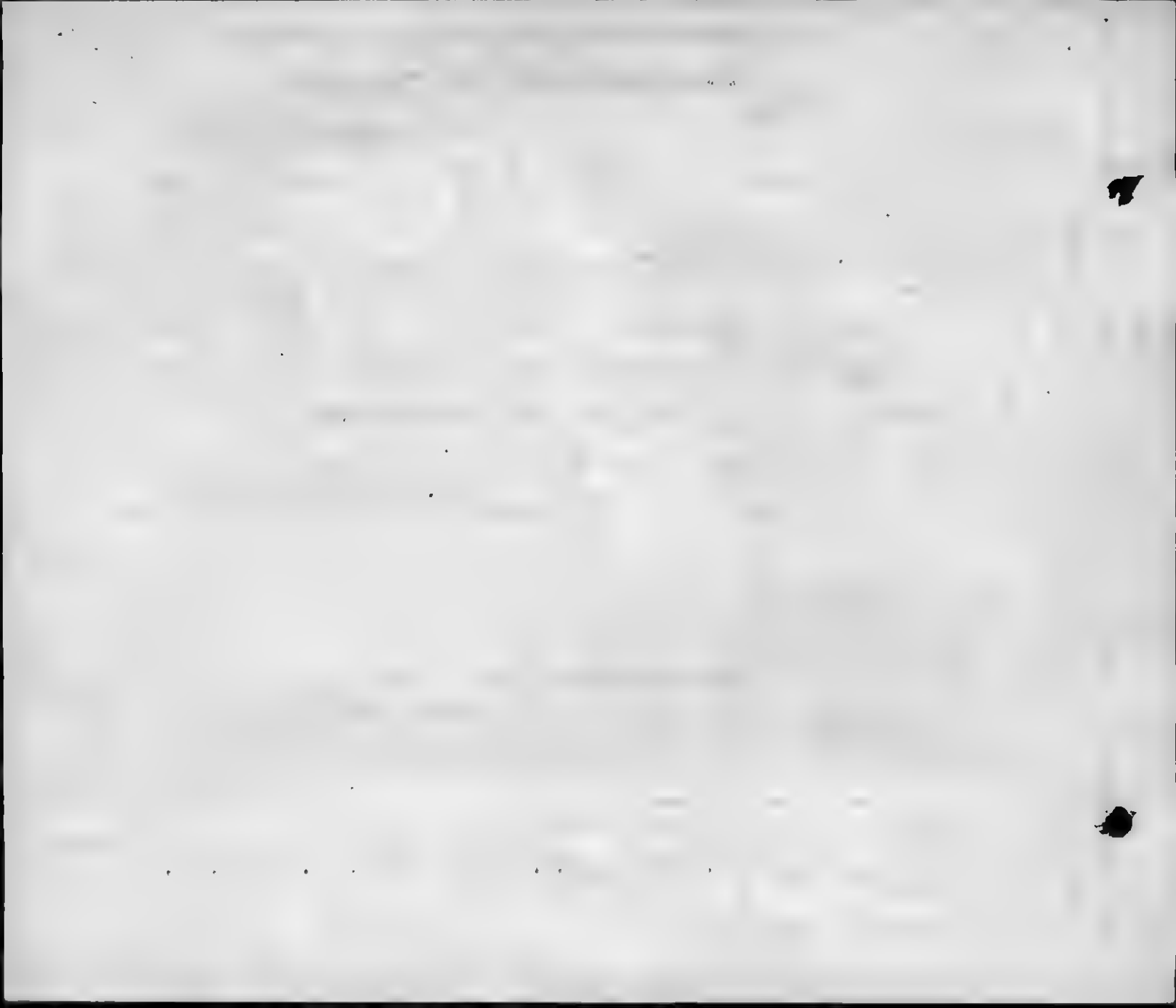
11077

11108

## CERTIFICATE OF DEATH

Reg. Dist. No. .... 32. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson</u>		<u>65 days</u>		TOWN <u>Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Raymond Albert Kelly</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 8 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-6-1900</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James F. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Marx Ida Hotel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>710-01-2307</u>		17. INFORMANT & ADDRESS <u>Hospital Records Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>				<u>9 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-4</u> , 19 <u>58</u> , to <u>10-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/13/59</u>		NAME OF CEMETERY OR CREMATORY <u>mt. Pleasant (U.B.)</u>		LOCATION (City, town, or county) (State) <u>Taneytown Md.</u>	
24. REC'D BY REGISTRAR <u>OCT 13 '59</u>		REGISTRAR'S SIGNATURE <u>Charles E. Rutz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Rutz</u> ADDRESS <u>Jarrettville</u>			





11109

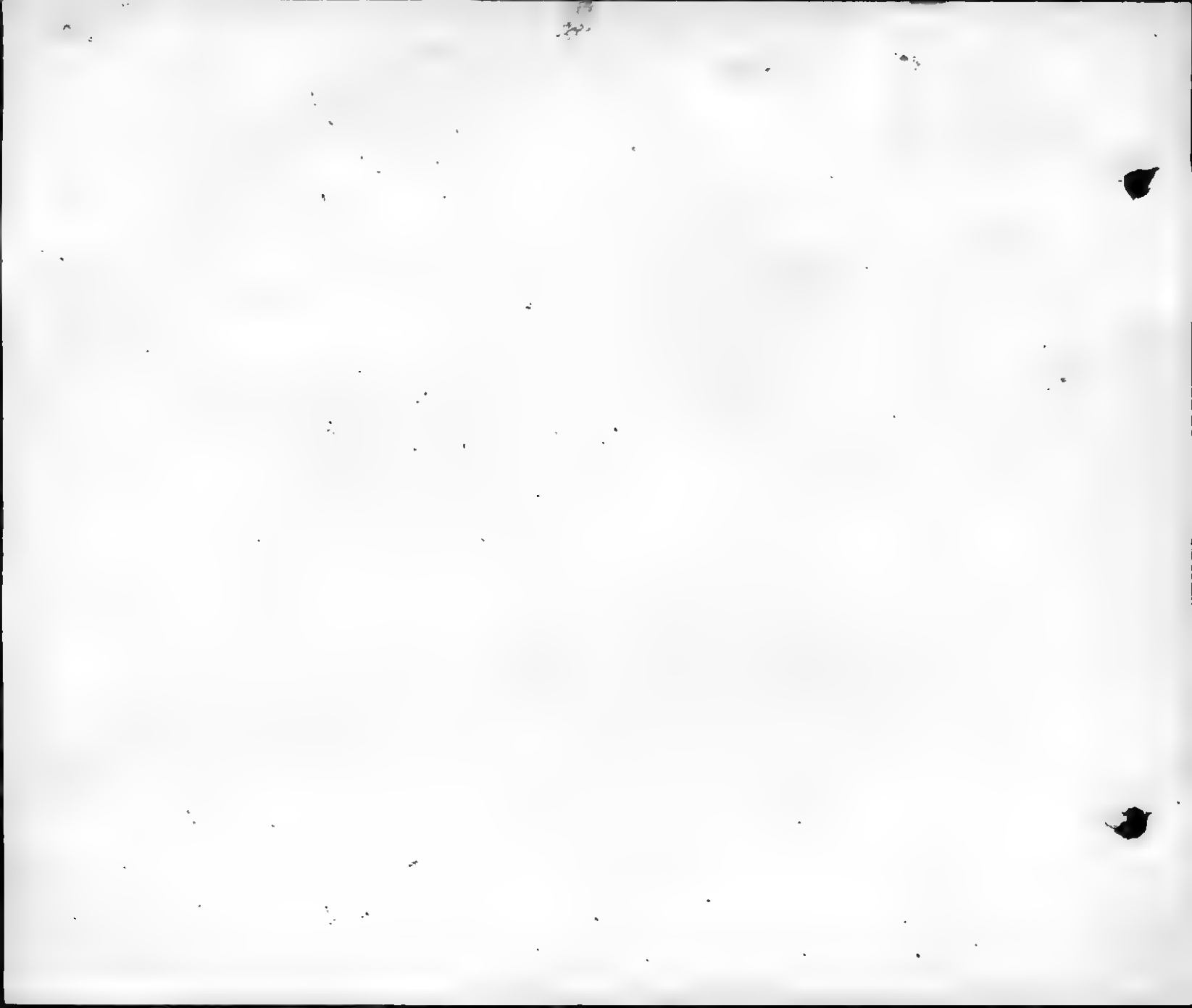
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>16 years</i>	
d. NAME OF HOSPITAL (If in hospital, give street address) <i>6613 Fairmount Avenue</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brighton</i>	
f. STREET ADDRESS <i>6613 Fairmount Avenue</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>George Henry Kerchner</i>		4. DATE OF DEATH Month Day Year <i>Oct 15 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22-1891</i>
9. AGE (In years last birthday) <i>68</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
13. FATHER'S NAME <i>George Kerchner</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Harble</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-22-7066</i>	
17. INFORMANT <i>Mrs. Adele M. Kerchner</i>		Address <i>6613 Fairmount Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>coronary thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic heart disease</i> (c) <i>few years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1954</i> to <i>15 Oct 1959</i> , that I last saw the deceased alive on <i>20 Aug 1959</i> , and that death occurred at <i>15 A.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Paul H Royse</i>		DATE SIGNED <i>15 Oct 59</i>	
PHYSICIAN'S NAME (Type) <i>Paul H Royse M.D.</i>		ADDRESS (Street, city or town, state) <i>Pikesville 8 Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 19 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Shrewsbury</i>	22d. LOCATION (City, town, or county) (State) <i>Shrewsbury Pennsylvania</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Horace F. Burge</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>3637 E. 1st Ave Baltimore</i>		DATE <i>OCT 19 59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11110

## CERTIFICATE OF DEATH

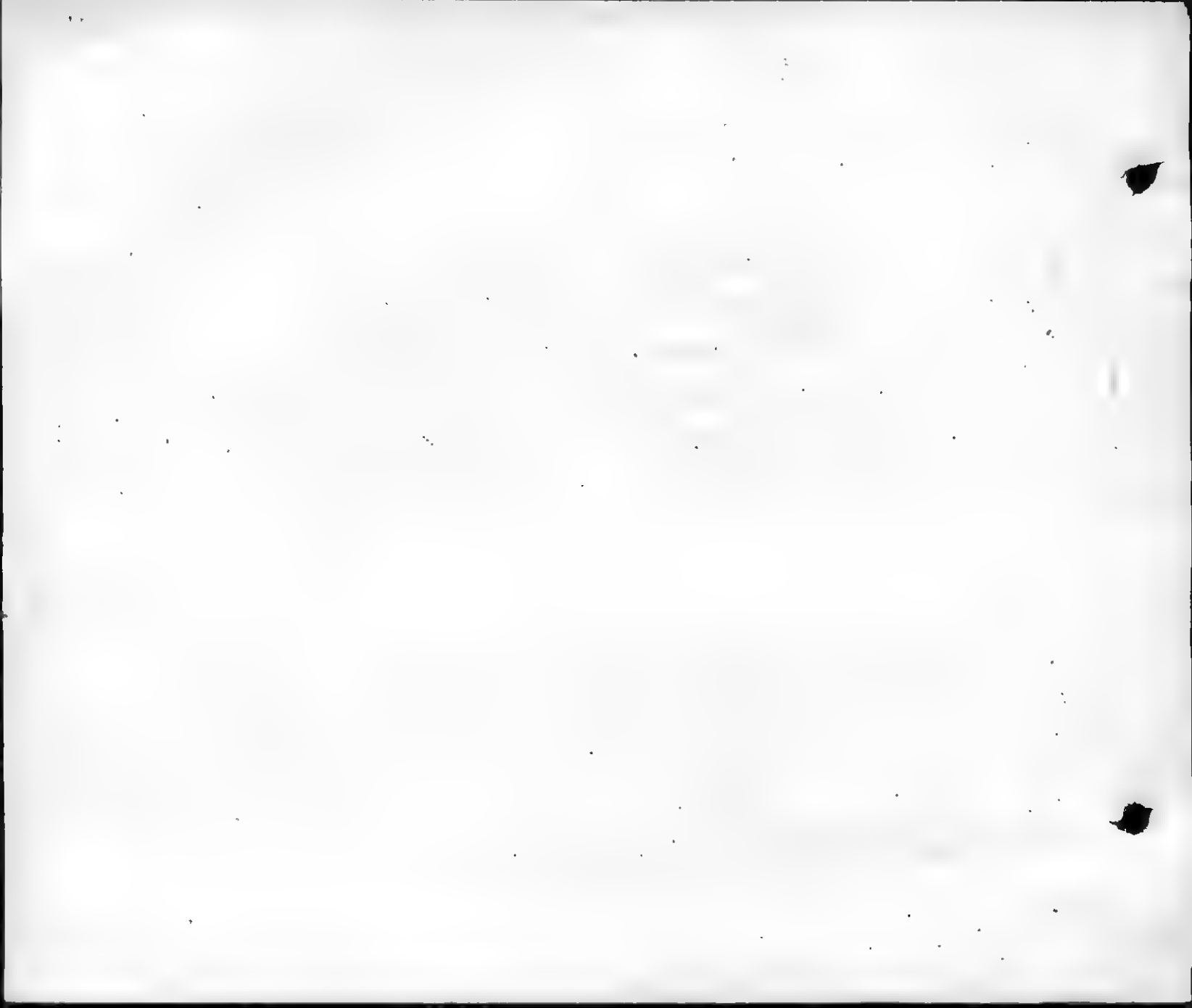
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE 28</u>		c. LENGTH OF STAY IN 1b <u>7 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6121 Northdale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE ISADOR KESTING</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 5, 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 14, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DANIEL SHAFER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CATHERINE KESTING</u> Address <u>6121 Northdale Rd, Catonsville 28, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> (b) <u>4</u> DUE TO (c) <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 15, 1954</u> , to <u>OCT 6, 1959</u> , that I last saw the deceased alive on <u>OCT 5, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman R. Kleiman</u> M.D.		ADDRESS (Street, city or town, state) <u>3803 Edmondson Ave</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>NORMAN R. KLEIMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Woodlawn Mausoleum</u>	22b. DATE THEREOF <u>10/8/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn, Temporarily</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Soud, Catonsville 28, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

The deceased Mrs. Grace I. Kesting, to be temporarily in crypt at Woodlawn Cemetery, later to be interred in Crest Lawn Cemetery, Howard Co.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



11013

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>46 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3116 Yorkway</b>		d. STREET ADDRESS <b>3116 Yorkway</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PAUL KIZMAN</b>		4. DATE OF DEATH <b>October 4, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Kizman</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Shepenthal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wm. Kizman 3438 Logan View Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1952</b> to <b>Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. W. Sokolov, M.D.</b>		ADDRESS (Street, city or town, state) <b>2900 Sumner Rd Dundalk-22-2nd</b>	
DATE SIGNED <b>10-5-59</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Kneass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

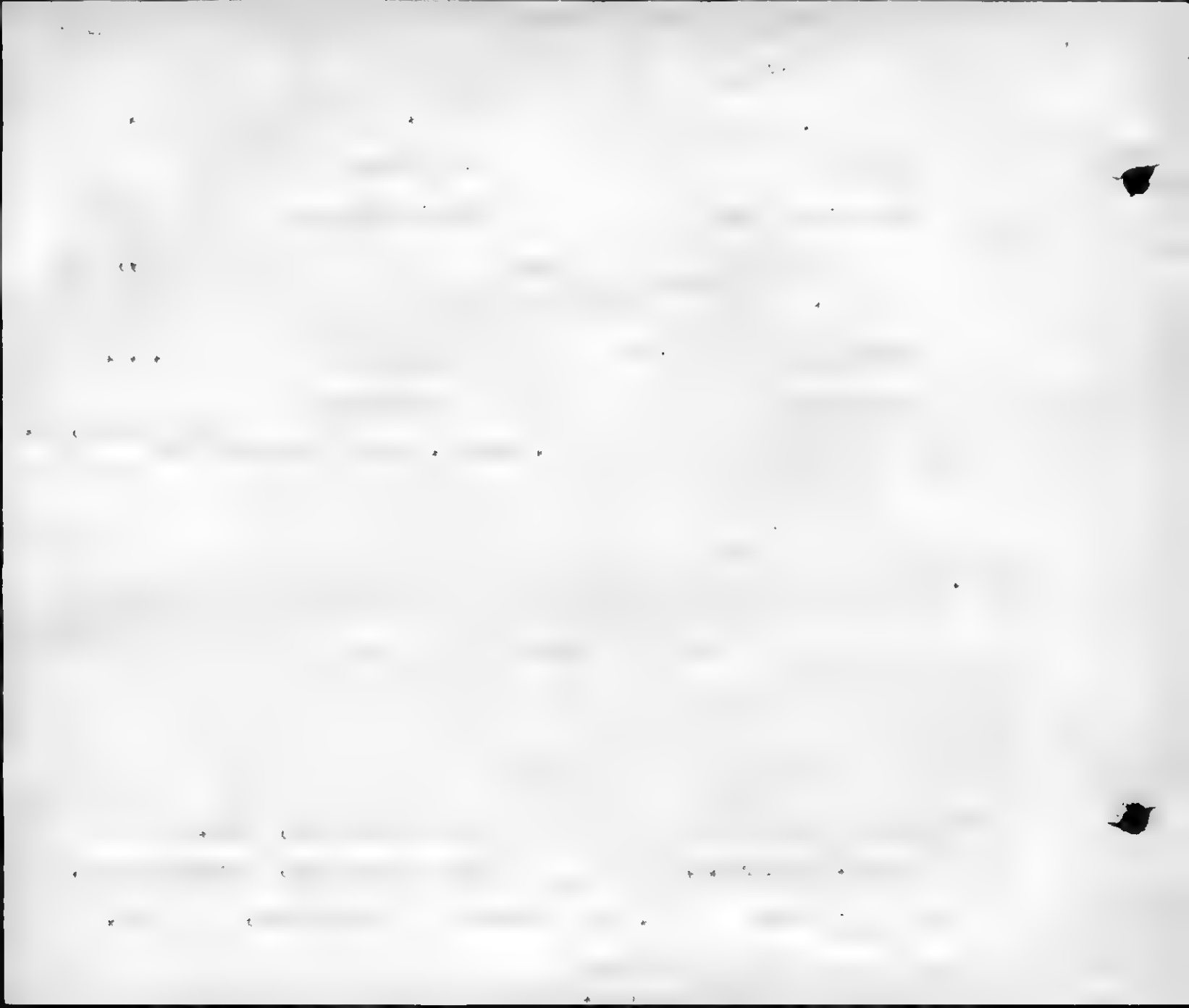
CERTIFICATE OF DEATH

11081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. LENGTH OF STAY IN 1b <b>X Randallstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8715 Liberty Road</b>		e. STREET ADDRESS <b>8715 Liberty Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>Klohr</b> Last (Type or print)		4. DATE OF DEATH Month <b>October</b> Day <b>20</b> , Year <b>1959</b>	
5. SEX <b>F/</b>	6. COLOR OR RACE <b>W.</b>	7. MARITAL STATUS <b>WIDOWED</b>	8. DATE OF BIRTH <b>8/6/76</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Bowen</b>	
14. MOTHER'S MAIDEN NAME <b>Temple Hale</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>*****</b>		17. INFORMANT <b>Mr. James A. Klohr 8715 Liberty Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA - COMMONDUCT - C</b> DUE TO (b) <b>METASTASIS TO LIVER.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MAY 1, 1954</b> to <b>OCT 20, 1959</b> , that I last saw the deceased alive on <b>OCT 20, 1959</b> and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas E. Wheeler M.D. 3601 Clifmar Road, Balto. 7</b>			
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b>		PHYSICIAN'S NAME (Type) <b>Thos E. Wheeler M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11112

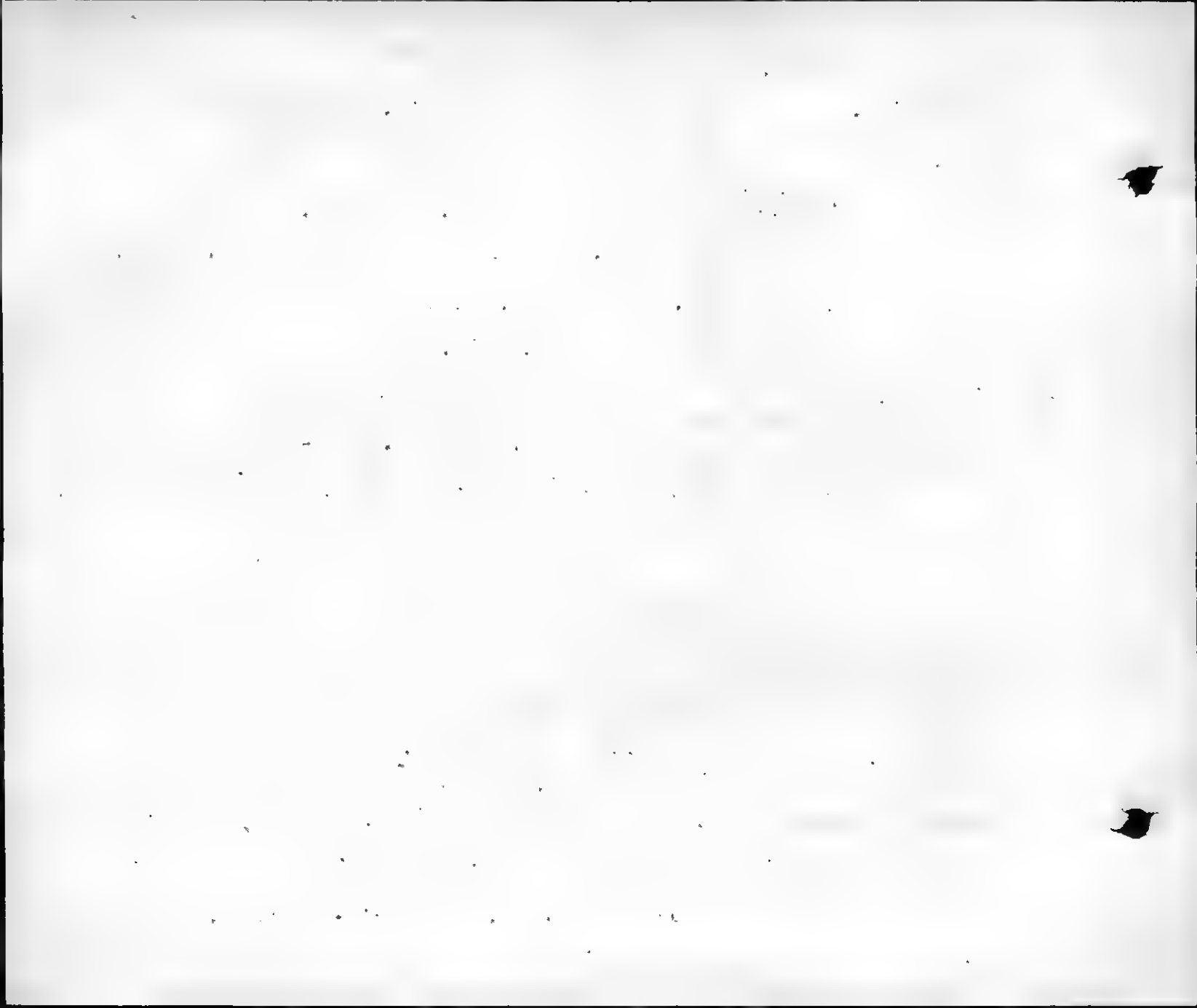
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>331 Stevenson Lane Holly Hill Nursing Home</b>				d. STREET ADDRESS <b>3507 N. Charles St.</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>KOLB</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>18,</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18, 1876</b>		9. AGE (In years last birthday) <b>83</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Mrs. Richard D. Cole - 625 Valley Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Decompensative Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 15, 1959</b> to <b>Oct. 18, 1959</b> , that I last saw the deceased alive on <b>Oct. 18, 1959</b> , and that death occurred at <b>7:15 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D.				ADDRESS (Street, city or town, state) <b>6805 York Rd. Baltimore 12 Md.</b>			
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>				DATE SIGNED <b>10/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Pickner &amp; Sons - Wa. St. 17</b>				24a. REC'D BY REGISTRAR <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

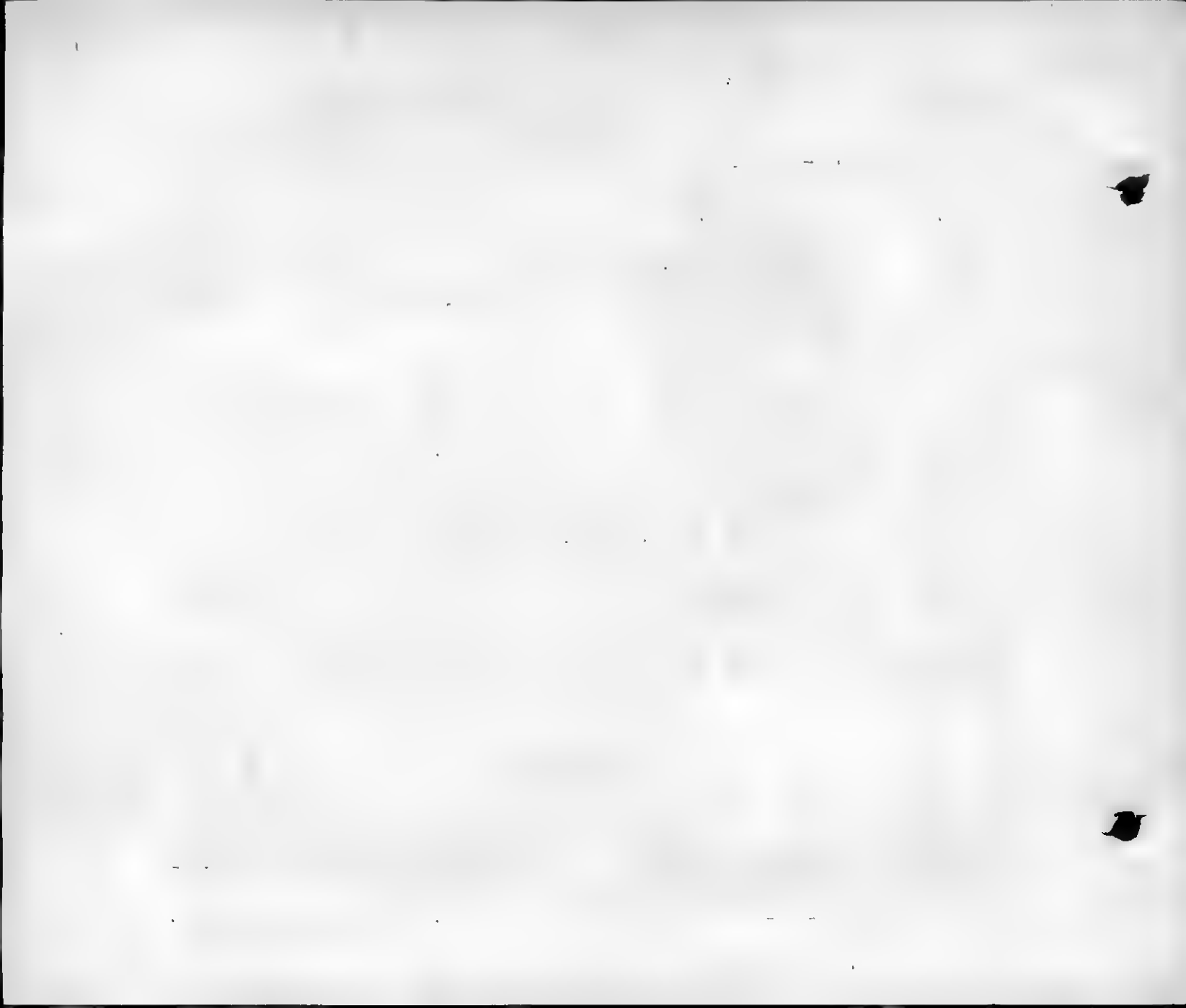
11083

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore--rural</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1306 Deanwood Ave.</b>						d. STREET ADDRESS <b>1306 Deanwood</b>			
3. NAME OF DECEASED (Type or print) <b>HERMAN HERMAN KRABBE</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>19</b> Year <b>19 59</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Mar 7, 1886</b>		9. AGE (in years last birthday) <b>73</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>operator</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Krabbe</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Minnie K. Krabbe</b> Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X Intracranial hemorrhage</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH <b>inst</b> <b>undet</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John C. Hyle</b>		EXAMINER'S NAME (Type) <b>JOHN C Hyle MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Rd</b>				24a. REC'D BY REGISTRAR <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11084

11114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shady Nook Conv. Home</i>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> d. STREET ADDRESS <i>Newbury Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Senora</i> Middle <i>Kriete</i> Last 5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>8/5/70</i> 9. AGE (In years last birthday) <i>89</i> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i> 11. BIRTHPLACE (State or foreign country) <i>Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>8</i> Year <i>1959</i>	
13. FATHER'S NAME <i>Herman Kriete</i> 14. MOTHER'S MAIDEN NAME <i>Amelia Bergner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: 16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Clarence Kriete</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the breast with metastases</i> <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) <i>XXXXXXXXXXXXXXXXXXXX</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>XXXXXXXXXXXX 19</i>		20d. INJURY OCCURRED While <i>Not at work</i> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>XXXXXXXXXX</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>October</i> , 1959, that I last saw the deceased alive on <i>7 October</i> , 1959, and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Millard T. Traband, Jr.</i>		ADDRESS (Street, city or town, state) <i>5101 Gwynn Oak Ave.</i> DATE SIGNED <i>9 Oct. 1959</i>	
PHYSICIAN'S NAME (Type) <i>Millard T. Traband, Jr.</i>		Baltimore, <i>7</i> , Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/12/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maubert &amp; Son</i> ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 13 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kriete</i>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11085

11115

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>334 UPPERLANDING RD.</u>		d. STREET ADDRESS <u>334 UPPERLANDING RD.</u>	
3. NAME OF DECEASED (Type or print) <u>ERIC K KUHNKE</u>		4. DATE OF DEATH <u>OCT. 21 19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-04</u>
9. AGE (in years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OTTO KUHNKE</u>		14. MOTHER'S MAIDEN NAME <u>W. DANNAMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>213-10-3485</u>	
17. INFORMANT <u>BARBARA KUHNKE - SAME AS ABOVE</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CH of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10-25-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>OCT 27 '59</u>	
ADDRESS <u>48 Eastern Blvd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11117

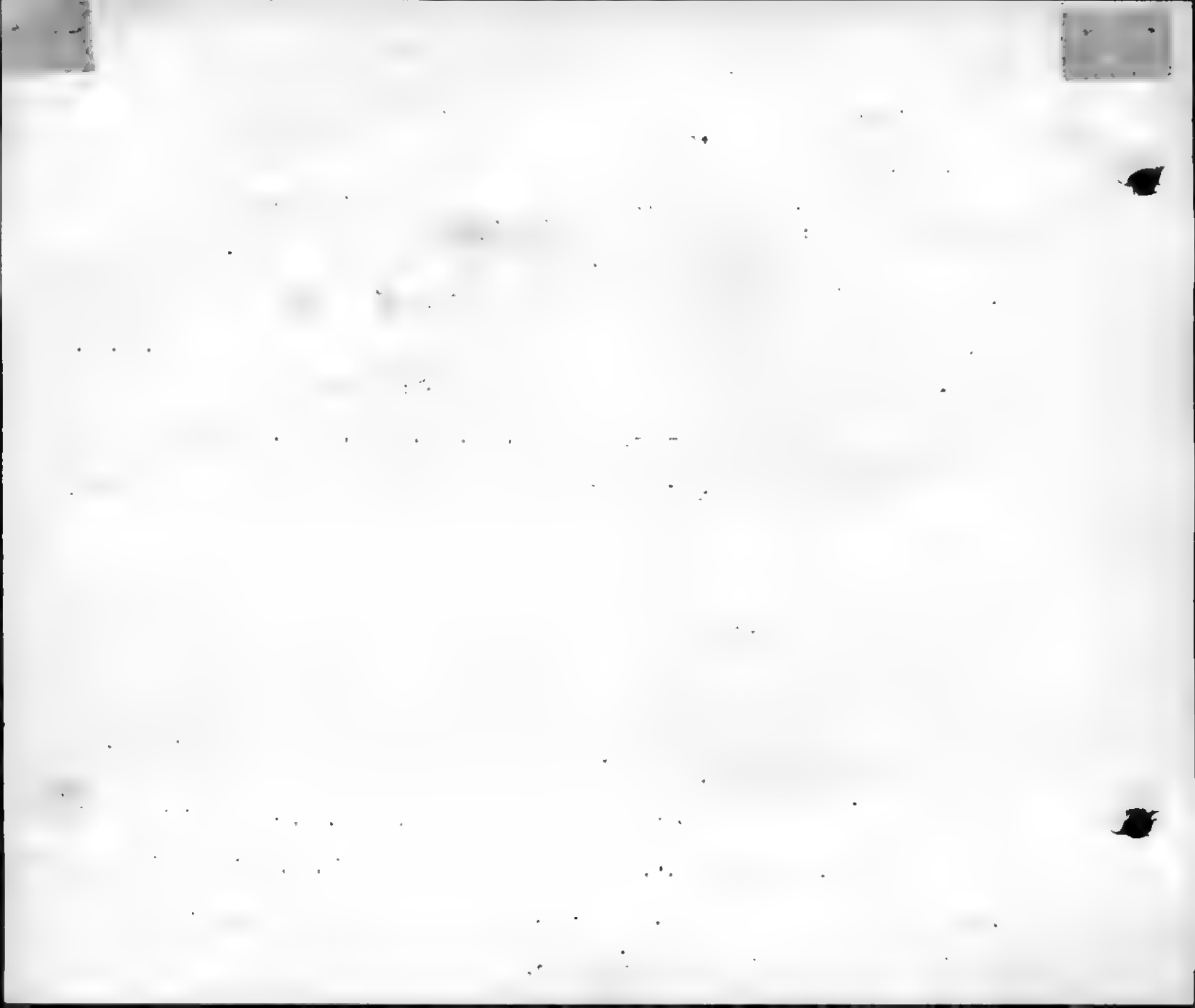
## CERTIFICATE OF DEATH

Reg. Dist. No.

11087

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>104 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>2531 Foster Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or print) (Served as: First <b>FRANK</b> (MIDDLE <b>KULESCZYK</b> ) <b>FRANK A. KULESCIEK</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>19</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 13, 1896</b>	
<b>9. AGE</b> (In years birthday) <b>63</b> yrs		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min		<b>11. IF UNDER 24 HRS</b> Months Days Hours Min		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Poland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Joseph Kuleszczyk</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia MN: Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>213-01-3421</b>			
<b>17. INFORMANT</b> <b>Clin. Rec. VAH. Balto. 18, Md. FORT HOWARD DIVISION</b>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (b) <b>351X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>Urinary tract infection</b>				<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20e. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <b>July 7, 1959, October 19, 1959</b>				<b>22. I certify that I last saw the deceased</b> <b>11:30 PM</b>			
<b>23. I certify that death occurred at</b> <b>11:30 PM</b>				<b>24. I certify that death occurred at</b> <b>11:30 PM</b>			
<b>ACTUAL SIGNATURE</b> <i>John W. Crawford</i>				<b>ADDRESS</b> (Street, city or town, state) <b>VAH, BALTO, 18, MD. FT. HOWARD DIVISION</b>			
<b>PHYSICIAN'S NAME (Type)</b> <b>JOHN W. CRAWFORD, M.D.</b>				<b>DATE SIGNED</b> <b>10/29/59</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Oct. 23, '59</b>			
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Stanislaus Cemetery</b>				<b>22d. LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>George Weber Funeral Home</b>				<b>24a. REC'D BY REGISTRAR</b> <b>OCT 22 '59</b>			
<b>24b. REGISTRAR'S SIGNATURE</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11116 Item 14 Film 3251 10-30-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>3201 Beverly Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hillendale Country Club</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wanda</u> <u>Nelanie</u> <u>Kunkowski</u>		4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>25</u> <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1906</u>
9. AGE (In years last birthday) <u>53</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Kedzierski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Dr Andrew Kunkowski</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary/CCU/Myocardial Infarction</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

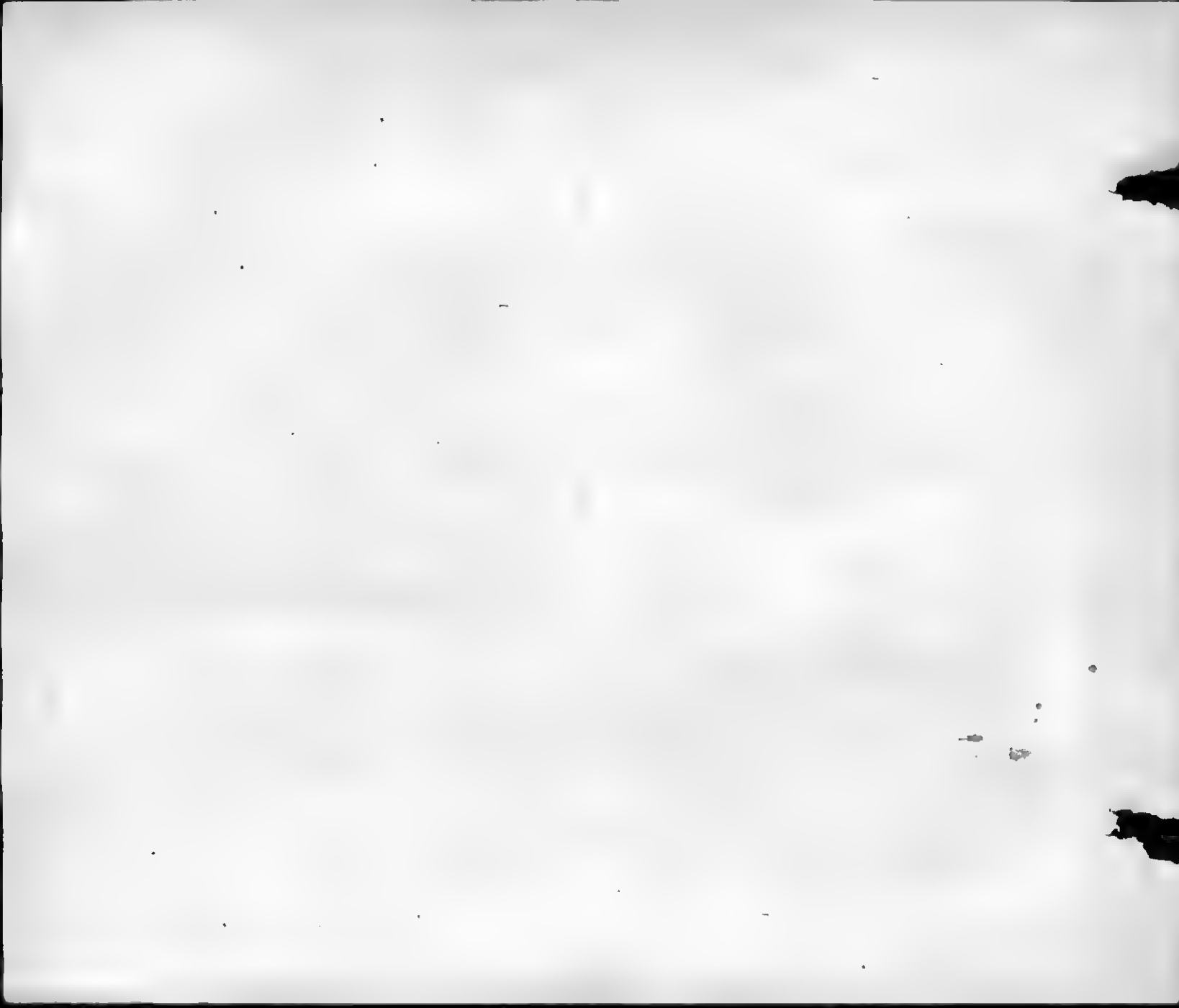
2

any, please  
clear. Page  
your files.  
the State Board of Health.  
hours after death.

1. This certificate should be executed within 24 hours after death. If any delay is anticipated, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 96 hours after death.

3. TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



11118

CERTIFICATE OF DEATH

Reg. Dist. No. 11088

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>817 St. Paul Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Jenny</b> Middle <b>Landy</b> Last <b>Landy</b>				4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1888</b>	
9. AGE (In years last birthday) yrs. <b>71</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Landy</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Bramson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 18, 19 59</b> , to <b>Oct. 2, 19 59</b> , that I last saw the deceased alive on <b>October 2, 19 59</b> , and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>10-2-59</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chel Yakov</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Lenson</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Caroline S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE (21)</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9 RIVERSIDE DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CHRISTIAN LOUIS LANG</b>			4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 28, 1896</b>		9. AGE (In years last birthday) <b>62</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RIGGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STANDARD OIL MD.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>CHRISTIAN LANG</b>			14. MOTHER'S MAIDEN NAME <b>CHRISTINA WEIGEL</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-01-4585</b>		17. INFORMANT <b>ANNA MAY LANG</b> Address <b>9 RIVERSIDE DRIVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Jack C Collins</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>JACK C Collins</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/19/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	
22d. LOCATION (City, town, or county) <b>BALTO. CO.</b>		22e. (State) <b>MD.</b>		22f. REC'D BY REGISTRAR <b>16 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Hoffmann</b>			24. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11120

## CERTIFICATE OF DEATH

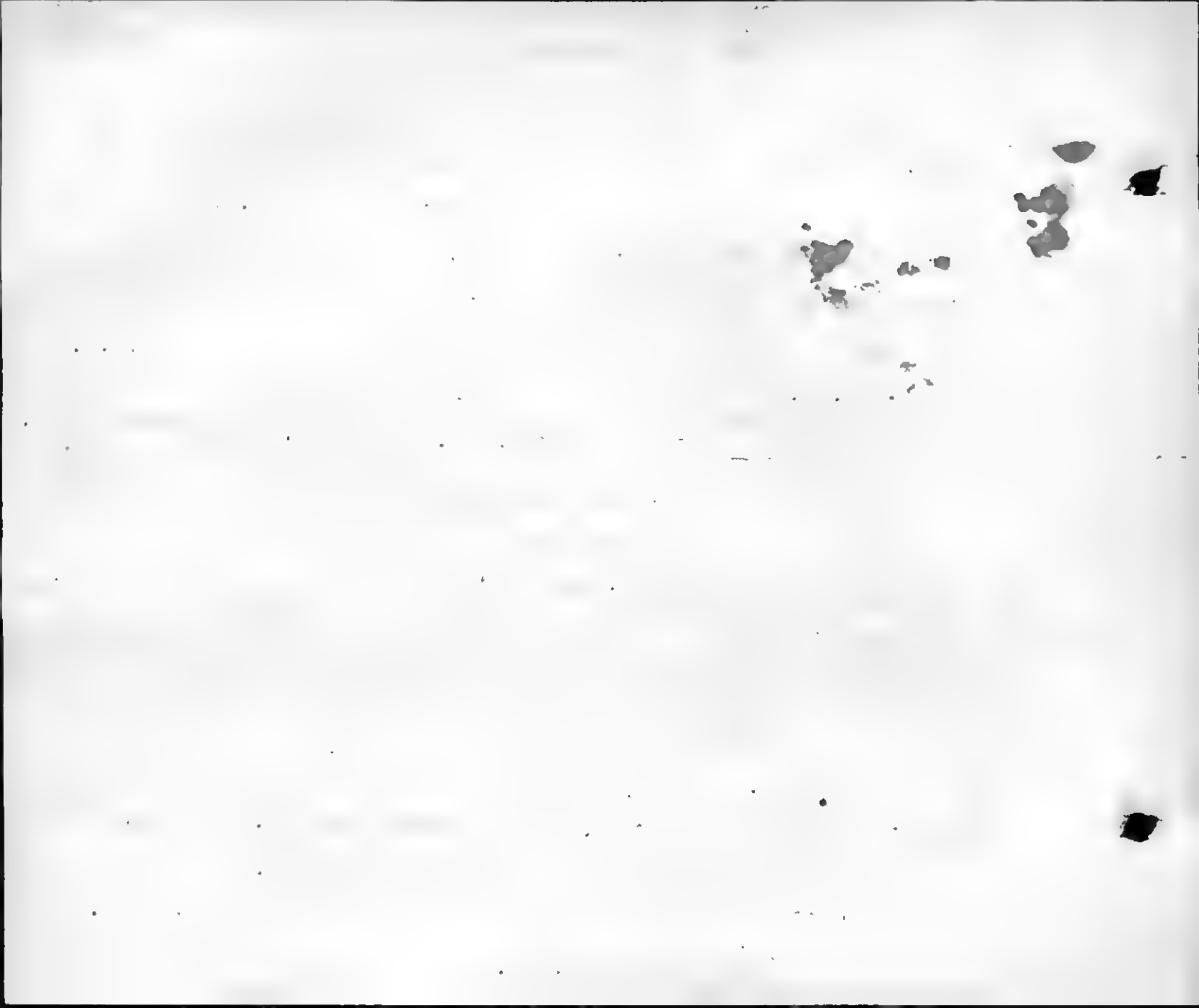
11090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>	
		f. STREET ADDRESS <b>Falls Road R.R.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Larmore</b> Last <b>Leaf</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>15</b> Min <b>00</b>	11. UNDER 24 HRS Hours <b>15</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Larmore</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Batchlor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>Robert M. Leaf</b>	
17. ADDRESS <b>Cockeysville, Falls Road Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-30</b> , 19, to <b>10-16-59</b> , 19, that I last saw the deceased alive on <b>10-15-59</b> , 19, and that death occurred at <b>3A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Reisterstown, Md.</b> DATE SIGNED <b>10-17-59</b> ACTUAL SIGNATURE <b>James G. Saffell</b> M.D. PHYSICIAN'S NAME (Type) <b>James Saffell</b> <b>Reisterstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grace Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>		24a. REC'D BY REGISTRAR <b>622 York Road Towson 4, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>OCT 20 1959</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11121

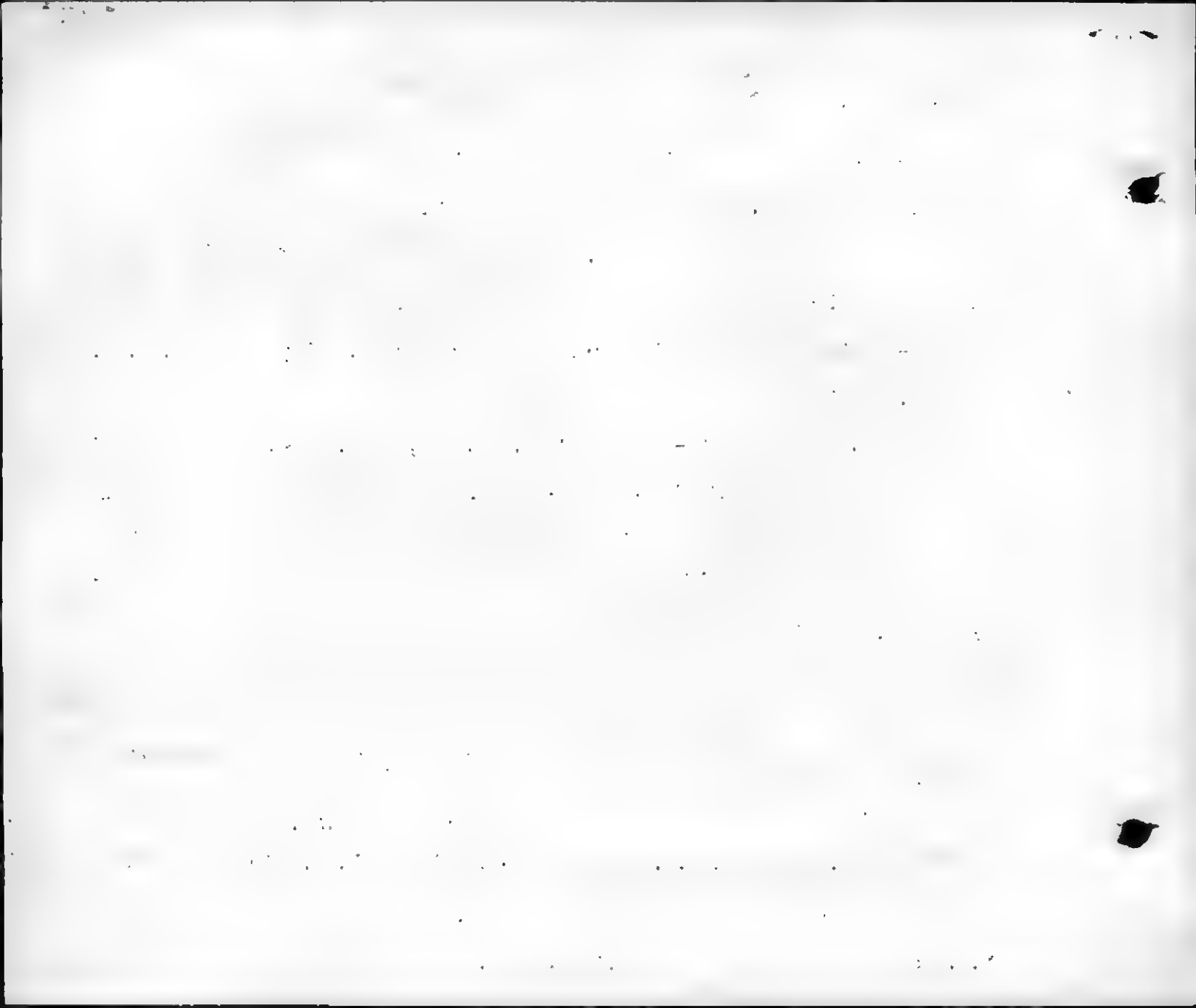
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN TB <b>13 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5207 Eugene Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>E.</b> Last <b>LEAKINS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 22, 1889</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.	11. IF UNDER 24 HRS Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline Station</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel E. Leakins</b>		14. MOTHER'S MAIDEN NAME <b>Laura Boone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>213-05-4743</b>	
17. INFORMANT <b>Clin. Rec., VAH, Balto. 18, Md.</b>		Address <b>Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>DIABETES MELLITUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>UNKNOWN</b> <b>31 YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia. Cardiac Decompensation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>10:10AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 15, 1959</b> to <b>October 28, 1959</b> , and that death occurred on the date stated above.			
ACTUAL SIGNATURE <b>John W. Crawford</b>		ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>10/28/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons, North &amp; Penna. Aves. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 29 '59</b>	
ADDRESS <b>Wm. J. Tickner &amp; Sons, North &amp; Penna. Aves. Balto. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11092

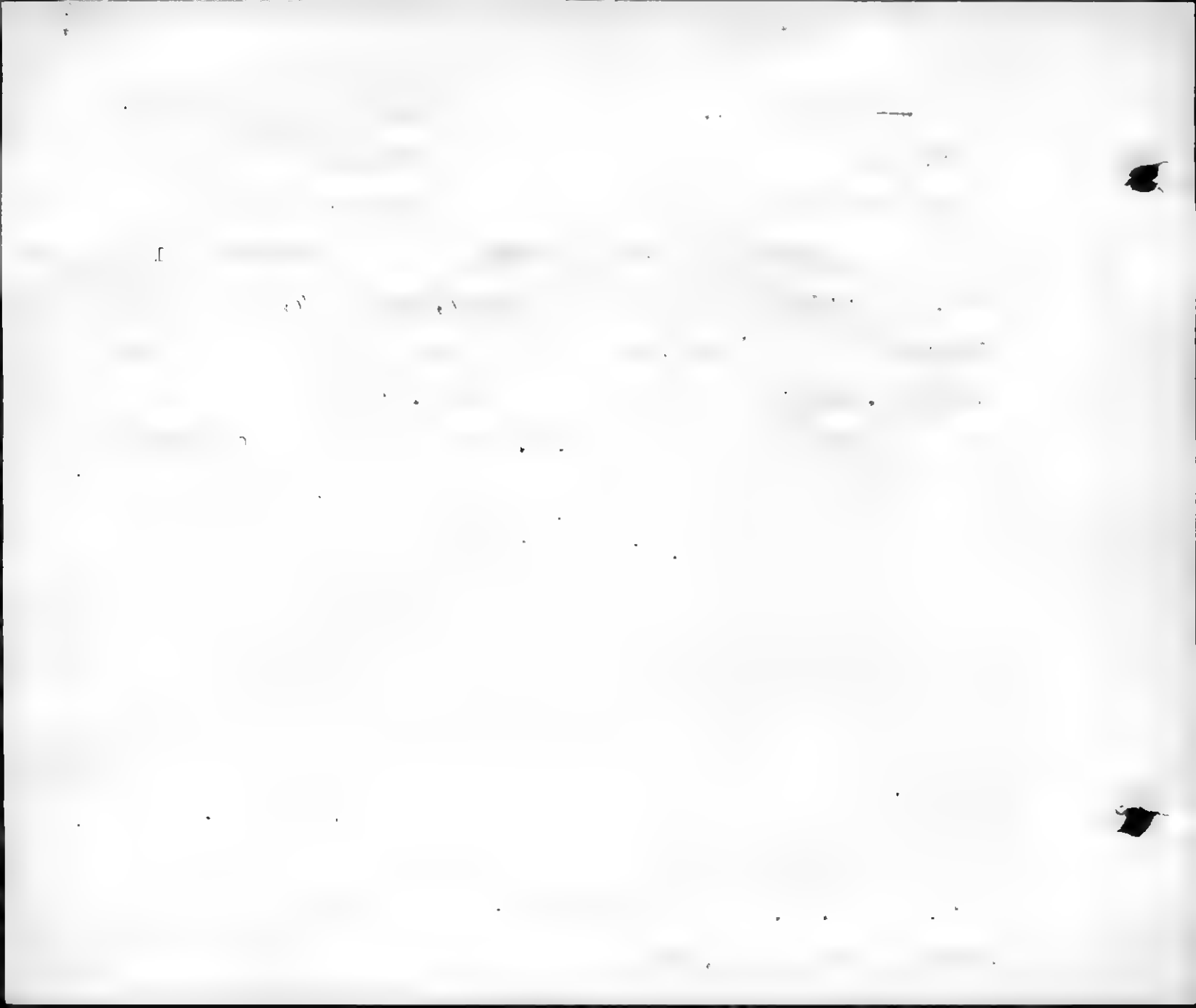
11122

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b> <b>MARYLAND</b>	2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>20 CROFTLEY ROAD</b>	d. STREET ADDRESS <b>20 CROFTLEY ROAD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SARA</b> Middle <b>ANNE</b> Last <b>LEHMAN</b>	4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MARCH 24, 1885</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>LEONARD A. COOPER</b>	14. MOTHER'S MAIDEN NAME <b>ANNE E. BURKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>297-05-638</b>	17. INFORMANT <b>MRS. FREDERICK GELTZ</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-vascular hemorrhage</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arteriosclerosis</b> DUE TO (c) <b>arteriosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>10 days</b>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 19, 1958</b> to <b>Oct 14</b> , 1959, that I last saw the deceased alive on <b>Oct 14</b> , 1959, and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Lutherville, Md</b> DATE SIGNED <b>10/16/59</b> ACTUAL SIGNATURE <b>George T. Gilmore</b> M.D. PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 17, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>OCT 20 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>		

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

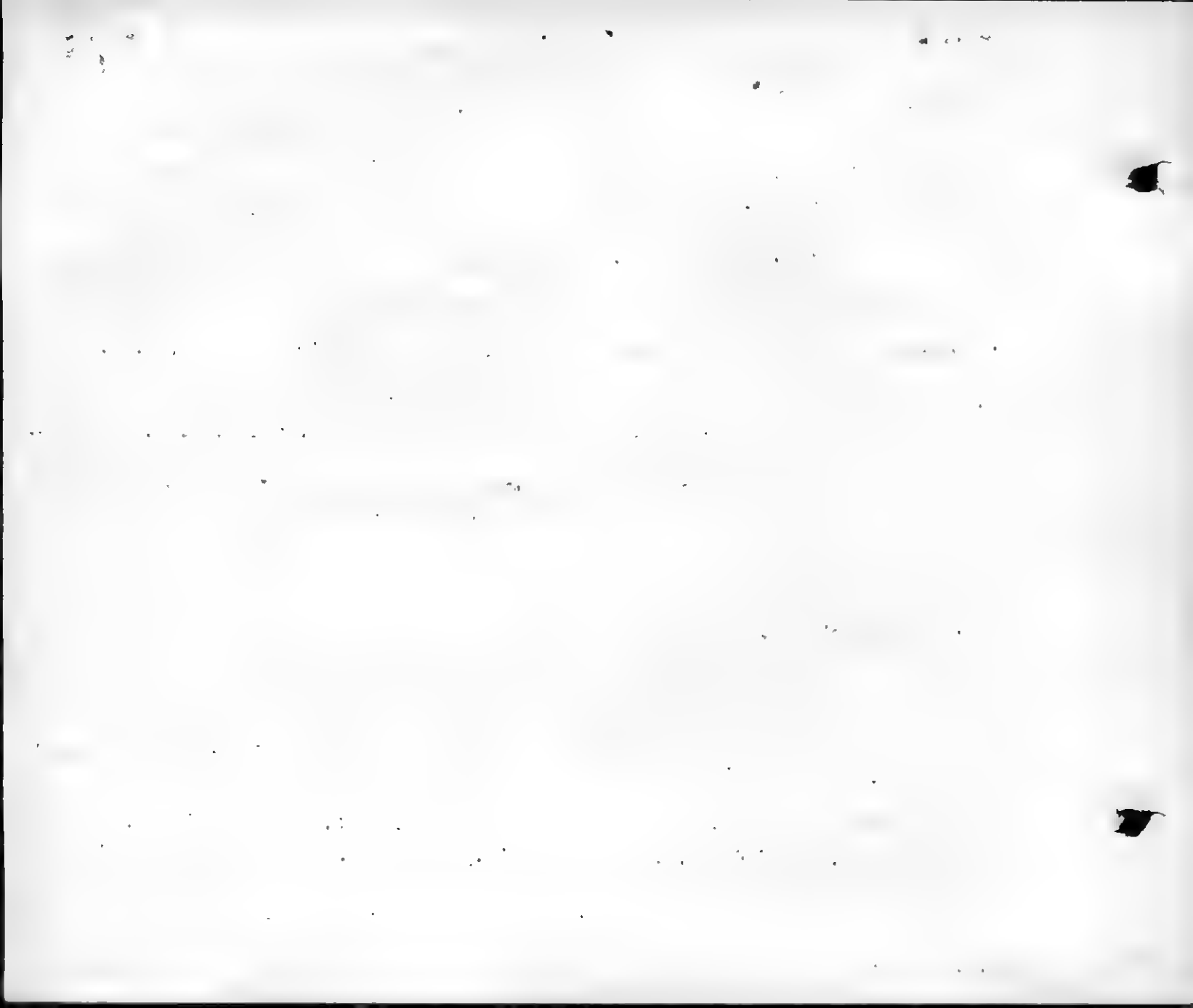
VS A15 (4)  
15M 9/58

11123 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

11093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>81 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUSSELL</b> Middle <b>C.</b> Last <b>LEONARD</b>		4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 5, 1896</b>
9. AGE (In years last birthday) yrs. <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>R. Hall Leonard</b>	
14. MOTHER'S MAIDEN NAME <b>Levinia Roberts</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> <b>WW I</b>	
16. SOCIAL SECURITY NO <b>214-34-4457</b>		INFORMANT Address <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG WITH METASTASIS TO THE LUNG PARENCHYMA, RIBS AND LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Moderate Cachexia.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 7, 1959</b> , to <b>October 27, 1959</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>John W Crawford</b>		M.D. <b>VAH, BALTO. 18, MD. FORT HOWARD DIV. 10/27/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louder Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner Funeral Home, North &amp; Penna. Aves. Balto. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Crawford &amp; Hanna</b>			





11094

11124

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

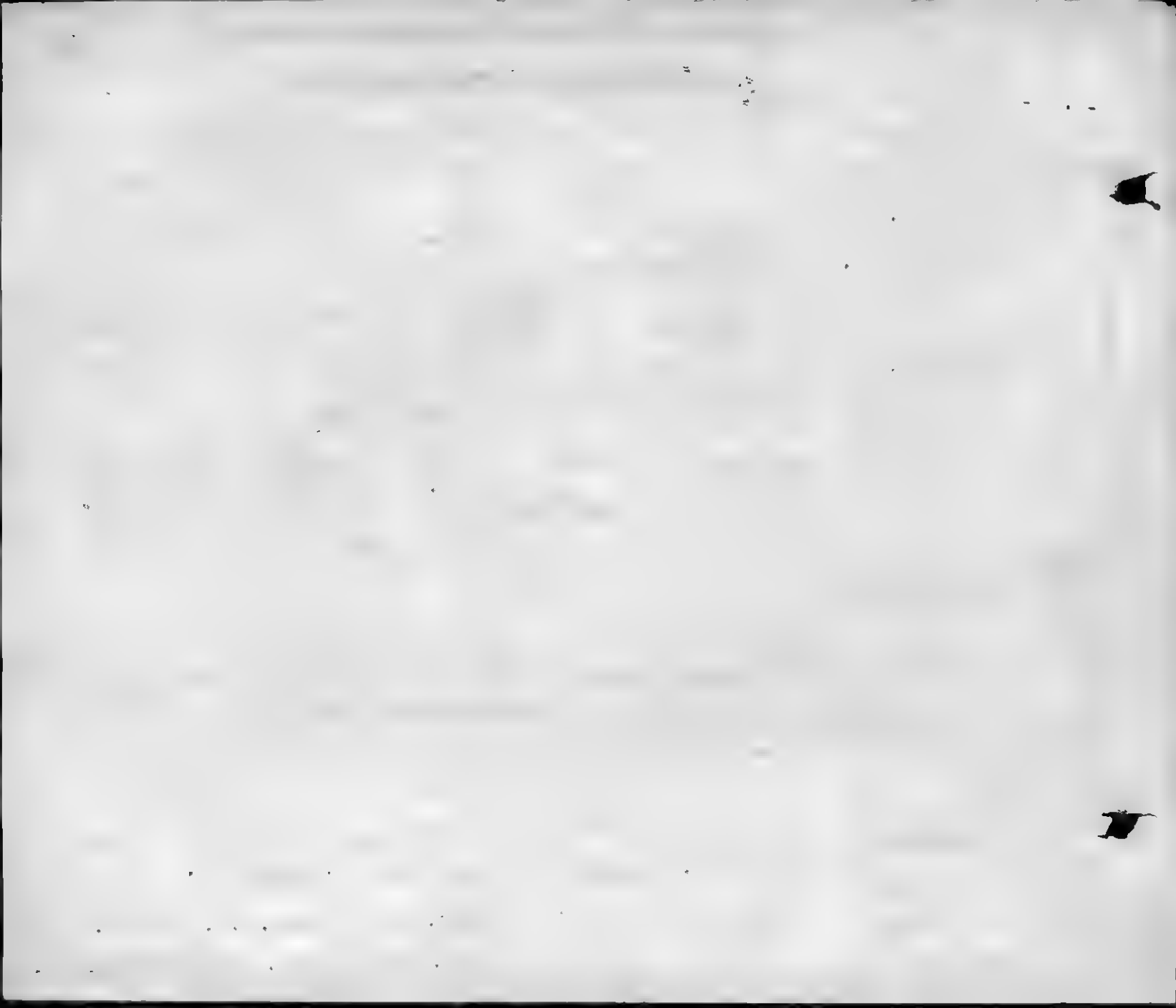
INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Mt. Wilson</b>	LENGTH OF STAY (In this place) <b>12 months</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE City</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Mt. Wilson State Hospital</b>		STREET ADDRESS (If rural give location) <b>3614 HOWARD PARK AVE</b>	
3. NAME OF DECEASED (Type or Print) <b>GRACE INEZ LIGHTBOURN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 25 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9/21/94</b>
9. AGE last birthday <b>65</b> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE OWN HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES CLOPPER</b>		14. MOTHER'S MAIDEN NAME <b>ESTA POFFENBERGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT & ADDRESS <b>Hospital Records</b>		<b>Mt. Wilson State Hospital</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis</b>			<b>31 years</b>
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arteriosclerotic Cardiac Disease</b>			<b>Unknown</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from <b>10/21</b> , 19 <b>58</b> , to <b>10/25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/25</b> , 19 <b>59</b> , and that death occurred at <b>4:30 P.</b> M, from the causes and on the date stated above.		21f. HOW DID INJURY OCCUR?	
SIGNATURE <b>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</b>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>10/28/59</b>	
24. REC'D BY REGISTRAR <b>Wm. F. Bast &amp; Son., Boonsboro, Md.</b>		REGISTRAR'S SIGNATURE <b>Wm. F. Bast &amp; Son., Boonsboro, Md.</b>	
DATE <b>OCT 28 '59</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Bast &amp; Son., Boonsboro, Md.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11095

11023

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Artutius</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Artutius</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1200 Linden Ave</u>				d. STREET ADDRESS <u>1200 Linden Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hollis S Linder</u>				4. DATE OF DEATH <u>Oct 1 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 29/1901</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anne Arundell Co Md</u>	
13. FATHER'S NAME <u>Frank R Tubbs</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle V Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Louis F Linder</u> Address <u>1200 Linden Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast &amp; brain</u> <u>114X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) <u>Carcinoma of Uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9/2/53</u> , 19 <u>53</u> , to <u>Aug 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/3/59</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.				ADDRESS (Street, city or town, state) <u>Wassonville, Md</u>			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 5/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wheatonridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry J. Hymacost</u> ADDRESS <u>4204 Ridgewood Ave</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Harris</u>	



11014

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>				c. LENGTH OF STAY IN 1b <b>Dundalk (22)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>803 Wise Avenue</b>				d. STREET ADDRESS <b>803 Wise Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>FRISBY</b> Middle <b>+++++</b> Last <b>LLOYD, Jr.</b>				4. DATE OF DEATH Month <b>October</b> Day <b>31st</b> , Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1890</b>		9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meter Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frisby Lloyd, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Lynch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-09-4336</b>		17. INFORMANT <b>Mrs. Saddle W. Lloyd</b>		Address <b>same as #2</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fever, undetermined origin</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>49</b> , to <b>Oct 31</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 30</b> , 19 <b>59</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>33 Dundalk Avenue</b> DATE SIGNED <b>11/2/59</b>							
ACTUAL SIGNATURE <b>David H. Andrew</b>			M.D. <b>33 Dundalk Avenue</b>				
PHYSICIAN'S NAME (Type) <b>David H. Andrew, M.D.</b>			<b>Baltimore 22, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Books Bradley, Inc.</b>				ADDRESS <b>Dundalk 22</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 4 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

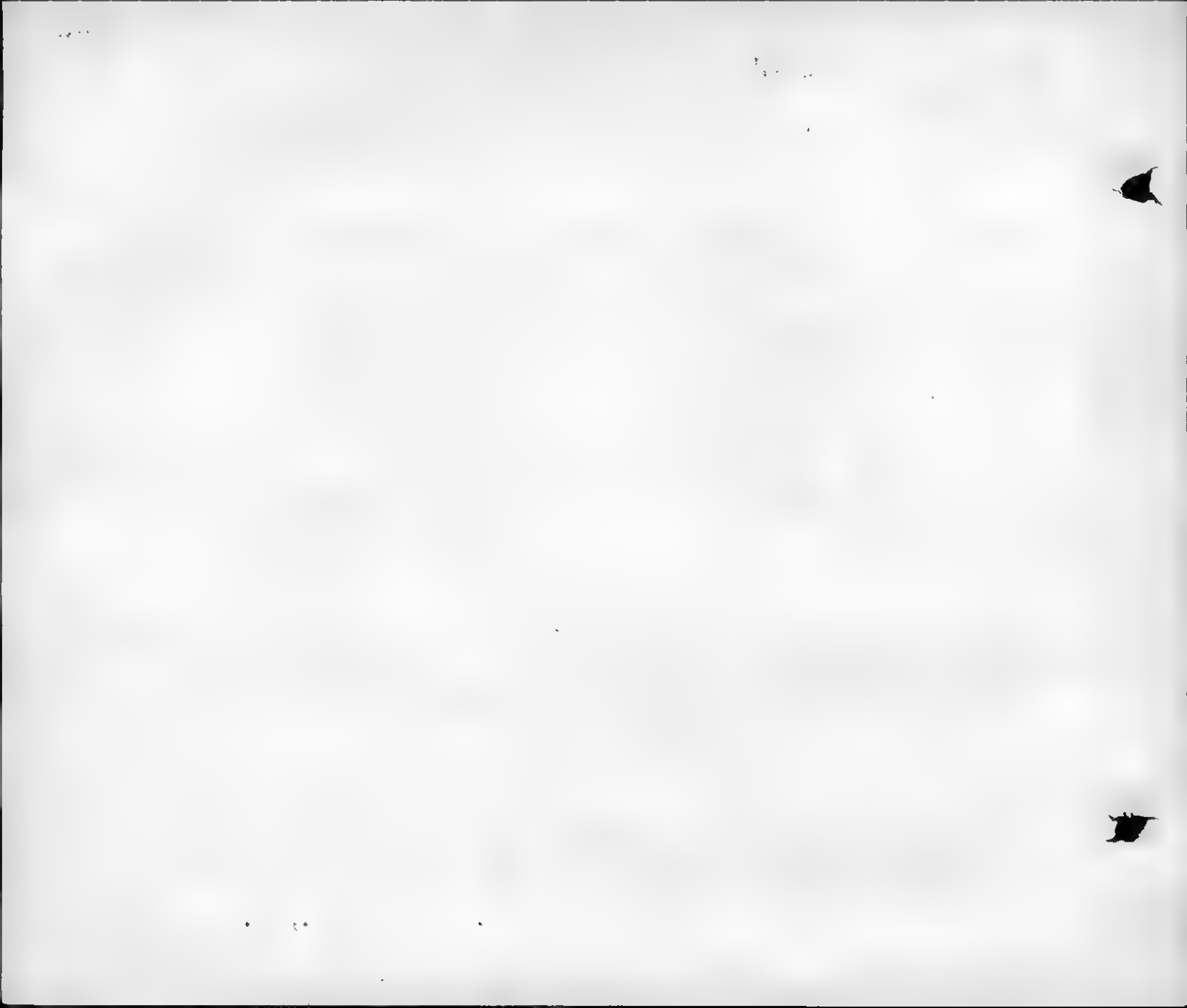
# Item 1 of 10-17-59 11125 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u>	
c. LENGTH OF STAY IN 1b <u>16 yrs</u>		d. STREET ADDRESS <u>302 Lee Drive #28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH CHRISTINE LOHR</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/83</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>HENRY SCHAEFER</u>		14. MOTHER'S MAIDEN NAME <u>Christine Feinsetler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>daughter in law Mrs. Rita Lohr</u>		Address <u>302 Lee Drive #28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of gall bladder</u> 15-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 10</u> 19 <u>59</u> to <u>Oct 11</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 10</u> 19 <u>59</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John H. Gerwig Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>400 Loralan Rd Baltimore Md</u>	
PHYSICIAN'S NAME <u>JOHN M. GERWIG JR MD</u>		DATE SIGNED <u>10/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amey Lickert</u>		ADDRESS <u>4400 17th St Baltimore Md</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. Chas &amp; Thoma</u>	





11126

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>24</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARTERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 23</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Helen West Home</u>		d. STREET ADDRESS <u>327 S. Parrish St</u>	
3. NAME OF DECEASED (Type or print) <u>ROLO</u> First Middle Last		4. DATE OF DEATH <u>Oct 28</u> 19 <u>59</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 DEC 1887</u> 76 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>ILL</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>EDWARD KESSETER</u>		14. MOTHER'S MAIDEN NAME <u>HELEN CHAFFY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>HELEN K. EISSMANN</u> Address <u>512 N. 7th St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANEMIC SCLEAERID CARDIO- VASCULAR DISEASE -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>SENILITY</u> DUE TO (c) <u>STATIONARY LUNG</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/1</u> 19 <u>59</u> to <u>30/10/28</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10/28</u> 19 <u>59</u> , and that death occurred at <u>5 A</u> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		DATE SIGNED <u>10/29/59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>30 Oct 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Helen Cem</u>	22d. LOCATION (City, town, or county) (State) <u>CC Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Walters</u> ADDRESS <u>1000 E. 1st St</u>		24a. REG'D BY REGISTRAR <u>NOV 2 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>William E. Thayer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>X Owings Mills, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lyons Mill Road</u>		e. IS PLACE OF DEATH ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert Ridgely Lutz</u>		4. DATE DEATH <u>October 19, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Lutz</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Devese</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO <u>217-22-7621</u>		17. INFORMANT <u>Mr. Elmer S. Tillman, 6 Taner Ave. Lexington Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bullet wound in mouth &amp; neck</u> DUE TO (b) <u>Mental Depression (Suicide)</u> DUE TO (c) <u>Gunshot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gunshot</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Bull. wound of gun in mouth &amp; pulled trigger</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-20-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 22, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikeville, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>			



11128

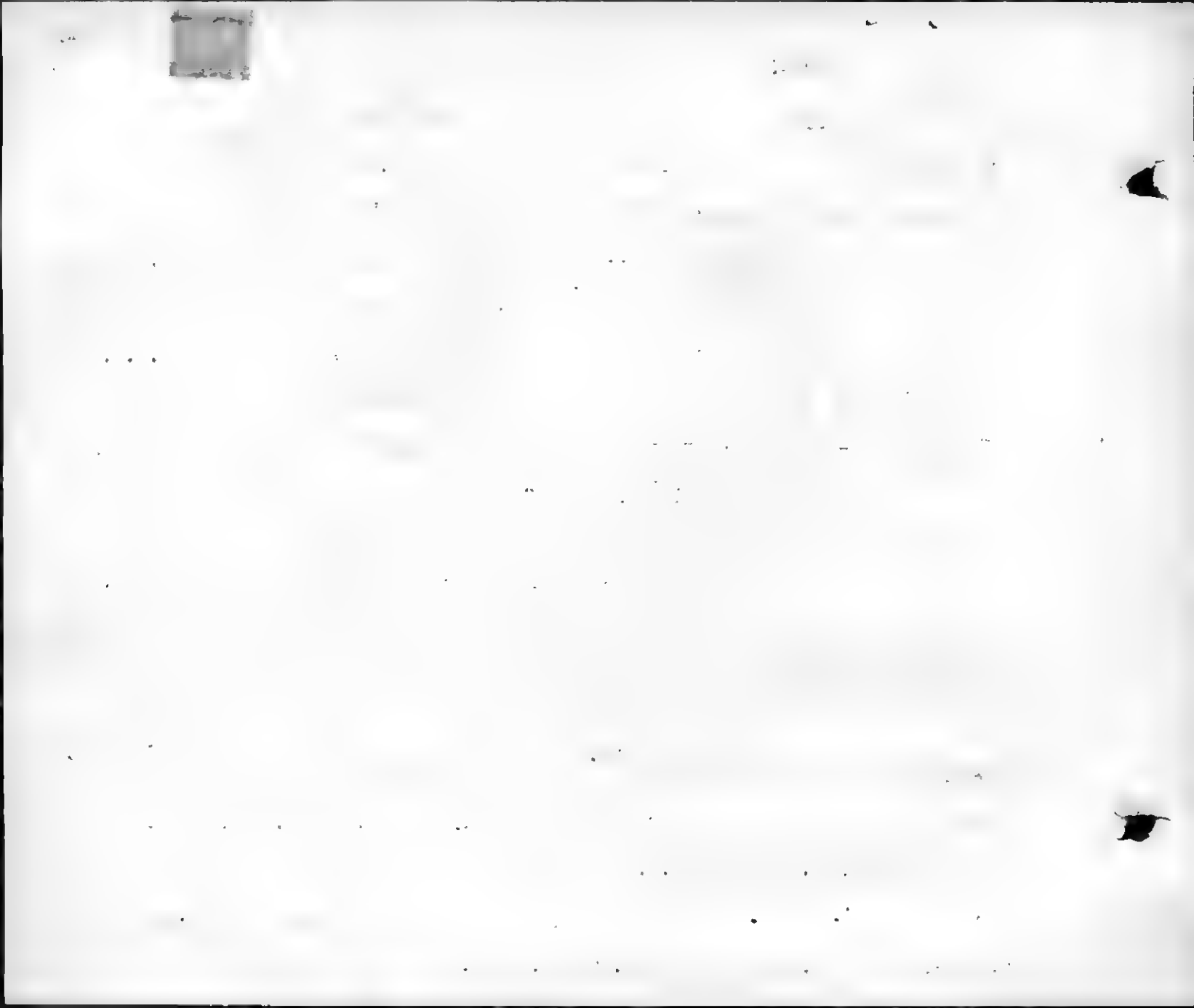
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>920 NORTH CALVERT STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>--</b> Last <b>LUTZ</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 8 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>59</b> Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK STATE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES LUTZ</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE SWARTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>213-34-1022</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARRHYTHMIA, CARDIAC</b> <b>422.1</b> DUE TO <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (c) <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>October 9, 1959</b> to <b>October 11, 1959</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTO 18, MD, FT. HOWARD DIV.</b> DATE SIGNED <b>10/12/59</b> ACTUAL SIGNATURE <b>HAROLD R. JOHNSON</b> M.D. PHYSICIAN'S NAME (Type) <b>HAROLD R. JOHNSON, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 13 59</b> 24b. REGISTRAR'S SIGNATURE <b>Charles A. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11015

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>85 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>88 Kinship Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
f. STREET ADDRESS <b>88 Kinship Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>M.</b> Last <b>LYNCH</b>		4. DATE OF DEATH Month <b>October</b> Day <b>24</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1866</b>
9. AGE (In years last birthday) <b>93</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Michael Ryan</b>		14. MOTHER'S MAIDEN NAME <b>? Fox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>John Lynch 88 Kinship Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>20 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-5</b> , 19 <b>57</b> to <b>10-24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-19</b> , 19 <b>59</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Kinship Rd Baltimore 22 Md</b> DATE SIGNED <b>10-25</b>			
ACTUAL SIGNATURE <b>Jack C Collins</b>		M.D. <b>10-25</b>	
PHYSICIAN'S NAME (Type) <b>Jack C Collins</b>		<b>Baltimore 22 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Colgate Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

11103

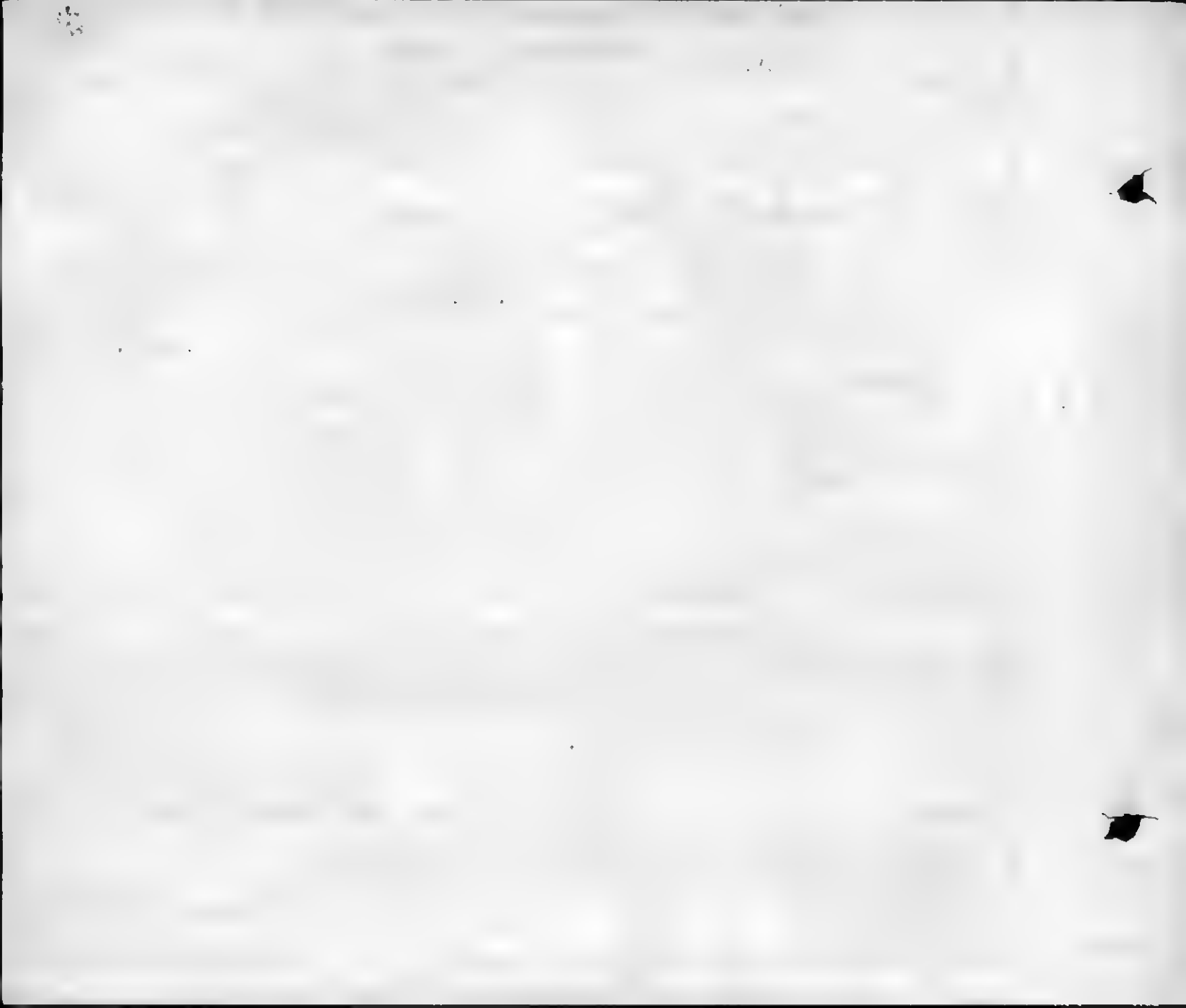
Reg. Dist. No.

11130

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1213 Hollins Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>F.</b> Last <b>MacKenzie</b>				4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1890</b>	9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland BALTO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Smith</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Keiser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Parkinson's Syndrome</b> (c) <b>Involutionary psychotic reaction</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 5, 1959</b> to <b>Oct. 15, 1959</b> , that I last saw the deceased alive on <b>Oct. 15, 1959</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>10/15/59</b>			
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10/20/59</b>		<b>Balto. National Cem. S.S.C. 1</b>		<b>Bethesda-Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Bowman</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

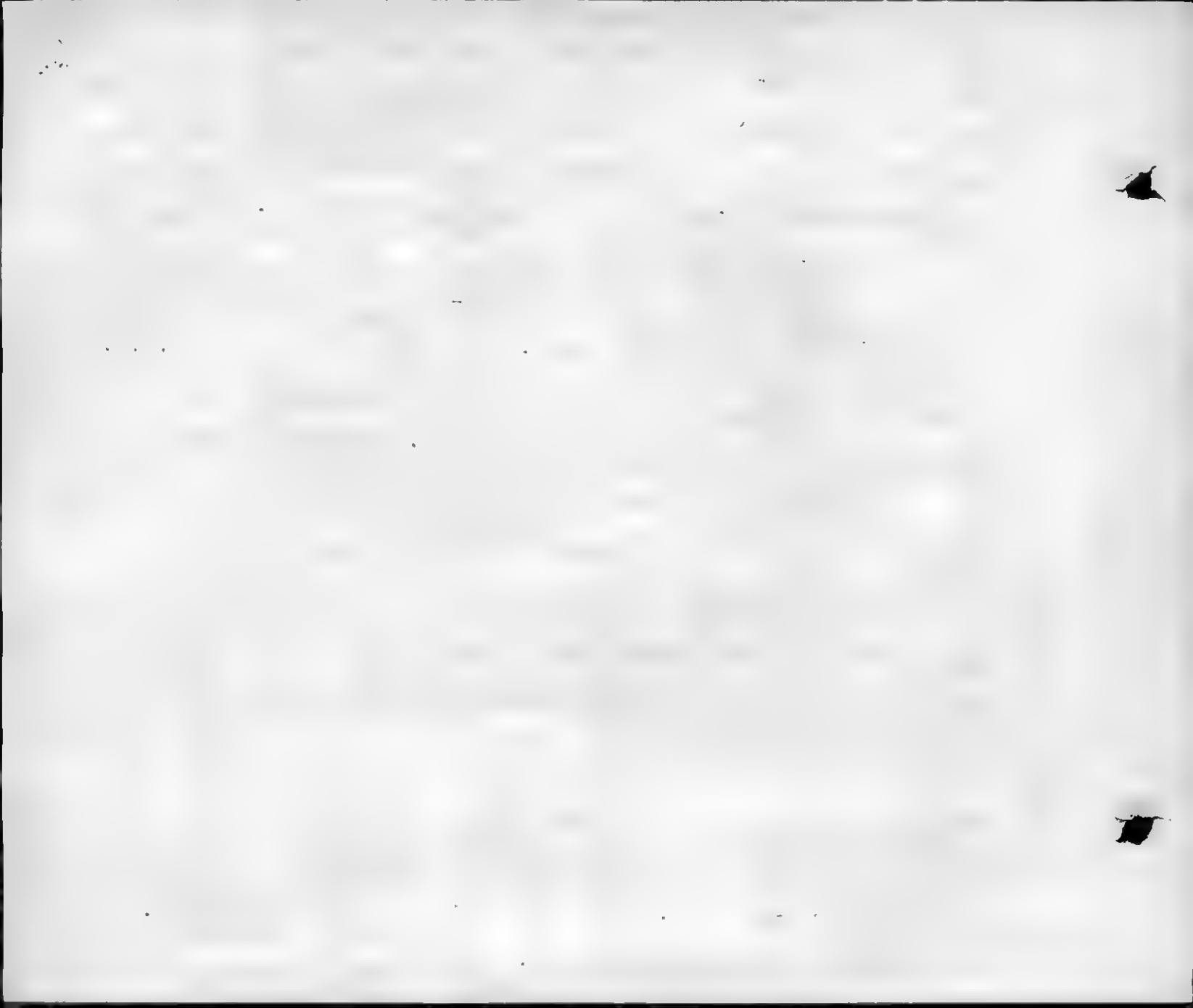
11102

Reg. Dist. No.

11129

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Michigan</b> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Detroit 19,</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>914 Ellendale Rd.</b>				d. STREET ADDRESS <b>22153 Pickford St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>John</b> Last <b>Mackle</b>				<b>4. DATE OF DEATH</b> Month <b>10-8</b> Day <b>19</b> Year <b>59</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12-19-1906</b>	
<b>9. AGE</b> (In years last birthday) <b>52</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS</b> Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Sales engineer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Petroleum prod.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Illinois</b>	
<b>13. FATHER'S NAME</b> <b>William Mackle</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Malvina Breckman</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>??????</b>		<b>17. INFORMANT</b> Address <b>Virginia V. Mackle above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Due to</b> <b>Chronic alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to</b> (b) <b>Due to</b> (c) <b>Due to</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <i>[Signature]</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <b>Charles F. C. Donnell</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>10/8/59</b> (State)			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10-12-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mary's Catholic</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Williamston, Mich.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Brooks Funeral Service, Towson 4, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE OCT 13 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11131

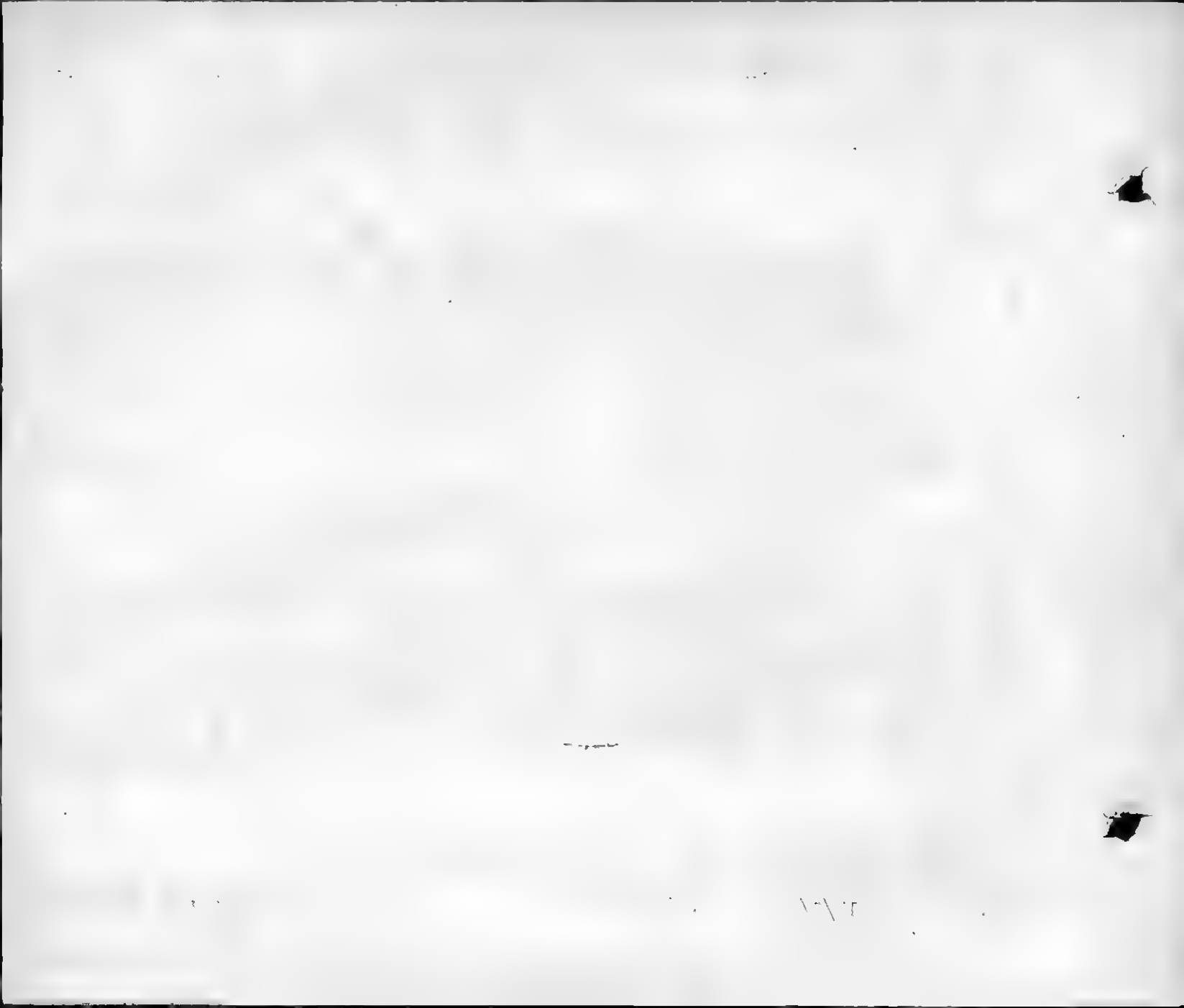
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Pyrlmthl4cys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>526 Park Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Elsbeth</b> Middle <b>Vaughan</b> Last <b>MacLean</b>				4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1907</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b> ✓
13. FATHER'S NAME <b>John Henry Ryan</b>				14. MOTHER'S MAIDEN NAME <b>Georgiana Vaughan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>NONE</b> <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>OCT 27, 1959</b> , to <b>OCT 29</b> , 1959, that I last saw the deceased alive on <b>OCT 29</b> , 1959, and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 10-29-59</b>							
ACTUAL SIGNATURE <b>Patrick K. Yip</b>				M.D. <b>SPRING GROVE STATE HOSPITAL 10-29-59</b>			
PHYSICIAN'S NAME (Type) <b>PATRICK K. Yip, M.D., Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SAINT MARTINS</b>		22d. LOCATION (City, town, or county) (State) <b>SAINT JOHN COUNTY, NEW BRUNSWICK CANADA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Bros. Johnson</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



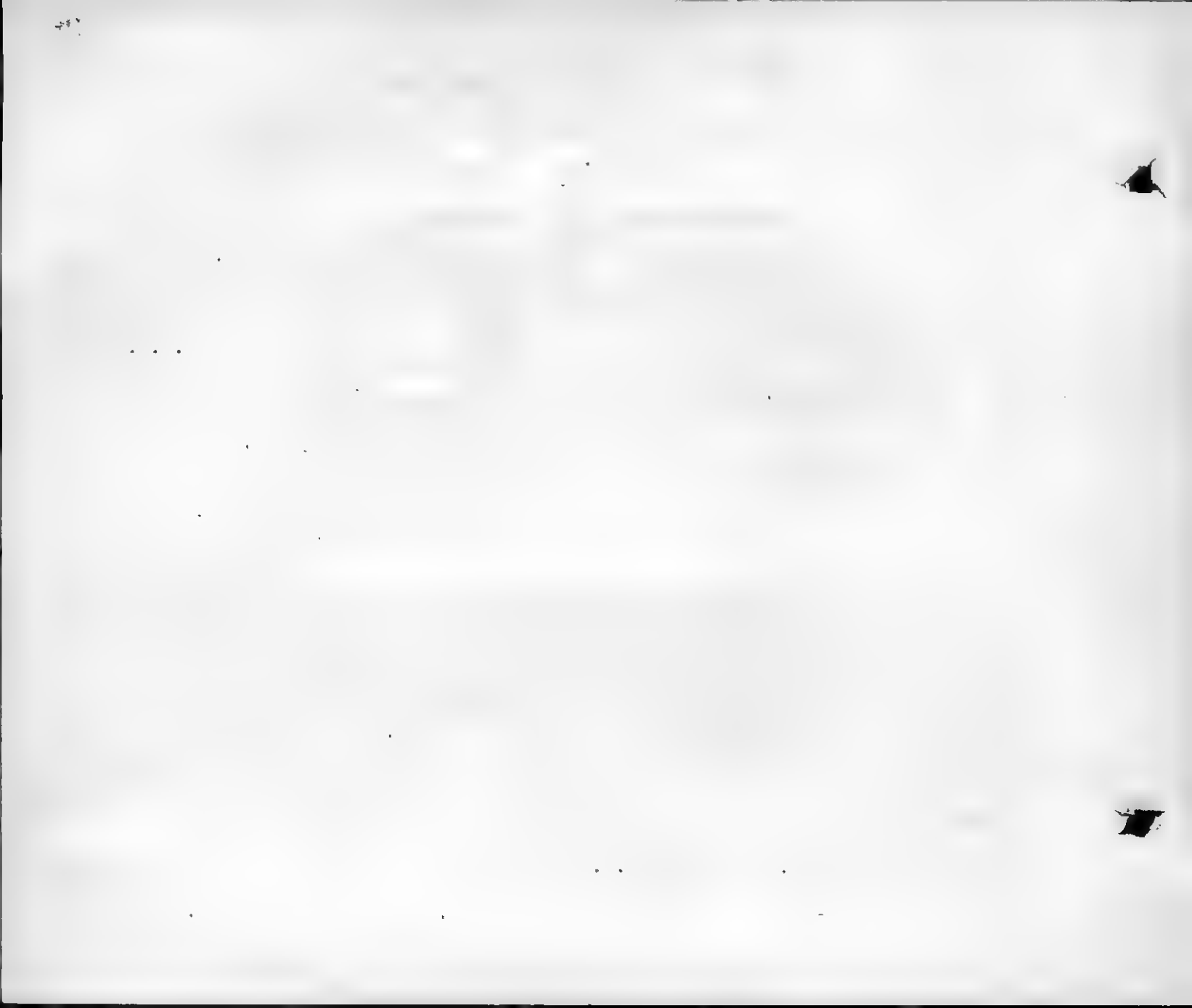
CERTIFICATE OF DEATH

Reg. Dist. No. 11105

11132

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson.</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson-4-- Stella Maris Hospice-- Maryland</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
f. STREET ADDRESS <u>318 Register Avenue</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Loretta</u> Last <u>Martindale</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4,</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min <u></u> IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank McFee</u>		14. MOTHER'S MAIDEN NAME <u>Margaret McFee Ann McKenna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Fielder Martindale, Jr.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Pneumonia</u> (c) <u>Wenckebach's Atrioventricular Block</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u> <u>5 Days</u> <u>10 1/2 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 8, 1954</u> to <u>October 4, 1959</u> that I last saw the deceased alive on <u>October 4, 1959</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>William J. O'Donnell M.D.</u>		ADDRESS (Street, city or town, state) <u>2501 17th Rd Baltimore, Md.</u>	
DATE SIGNED <u>10/4/59</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell - M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>10-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard R. Kuchling</u>		ADDRESS <u>5305 Hayford Rd</u>	
24a. REC'D BY REGISTRAR <u>Oct 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11133

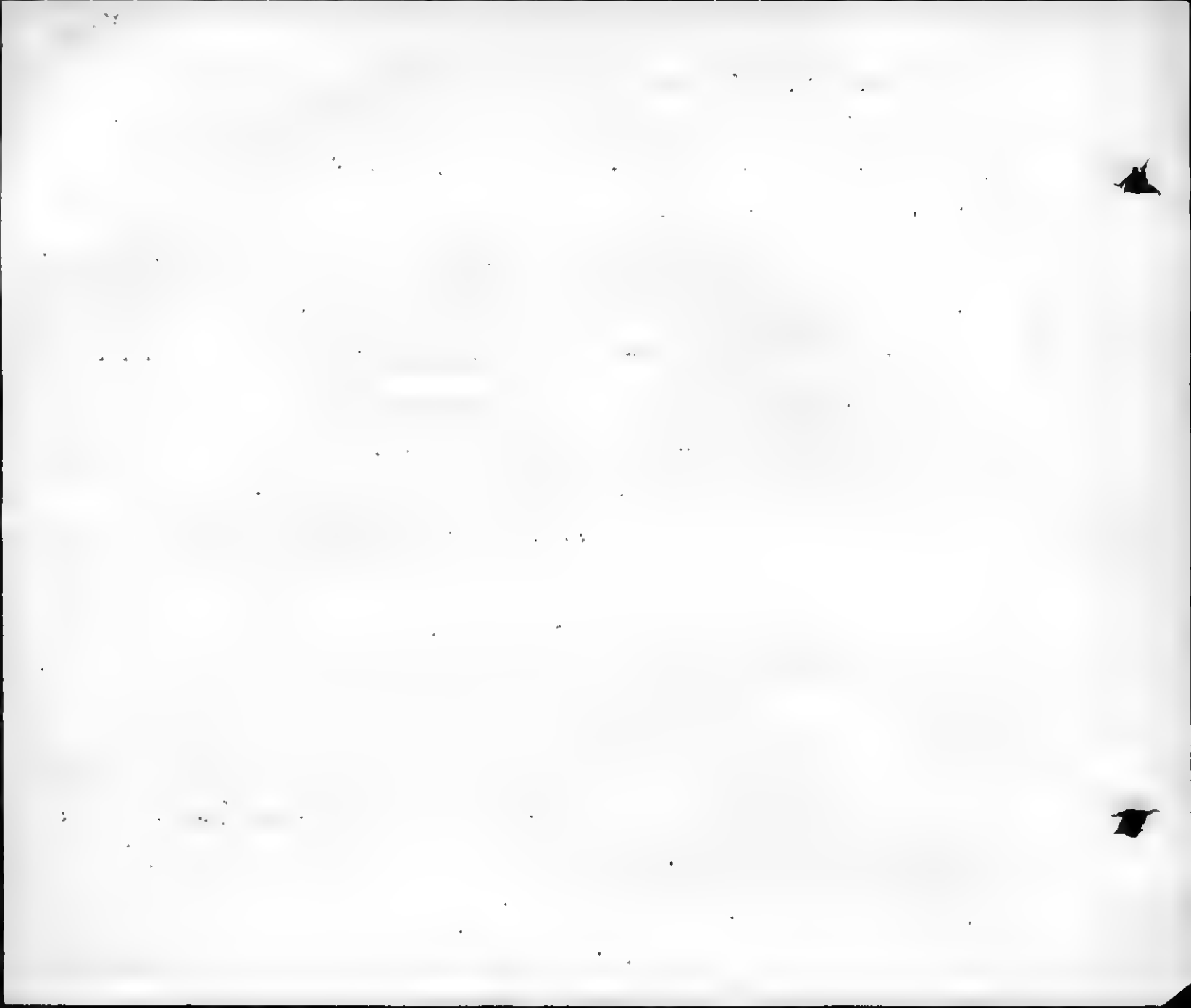
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Baltimore</u> MARYLAND				a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>9 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Essex, Maryland</u>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Virginia McAlpin</u>				4. DATE OF DEATH Month Day Year <u>10 23 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/42</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Percy Buford McAlpin</u>				14. MOTHER'S MAIDEN NAME <u>Cassie May Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO <u>no</u>			
17. INFORMANT <u>Rosewood Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent bronchopneumonia</u> DUE TO <u>of right lower lobe of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>491X</u> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculous scleritis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:50am</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John W. Rieckert Pathologist 4307 Mainfield Rd. 10/23/59</u>							
ACTUAL SIGNATURE <u>John W. Rieckert</u>				PHYSICIAN'S NAME (Type) <u>P. W. Rieckert Baltimore 14, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-26-59</u>		<u>Sacred Heart</u>		<u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly - Exec. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

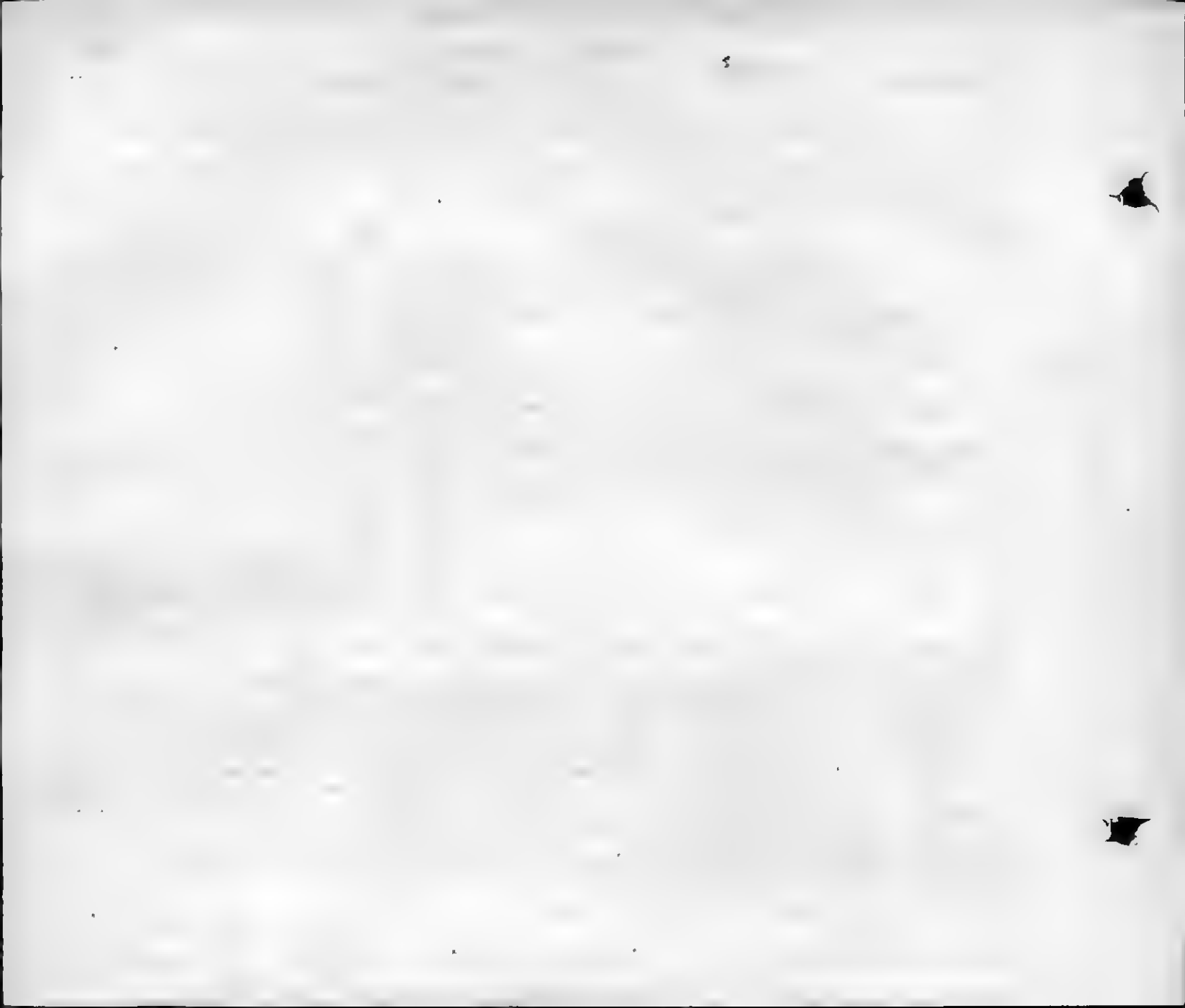
Reg. Dist. No. 11107

11134

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>2413 St. Paul Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Elizabeth</b> Last <b>McCarthy</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John T. Mack</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Alexander</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>Inanition due to mental illness</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 9, 1959</b> to <b>October 6, 1959</b> , that I last saw the deceased alive on <b>Oct. 6, 1959</b> , and that death occurred at <b>8:18 p.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 10-7-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 8 1959</b>	
ADDRESS <b>4905 York Rd</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

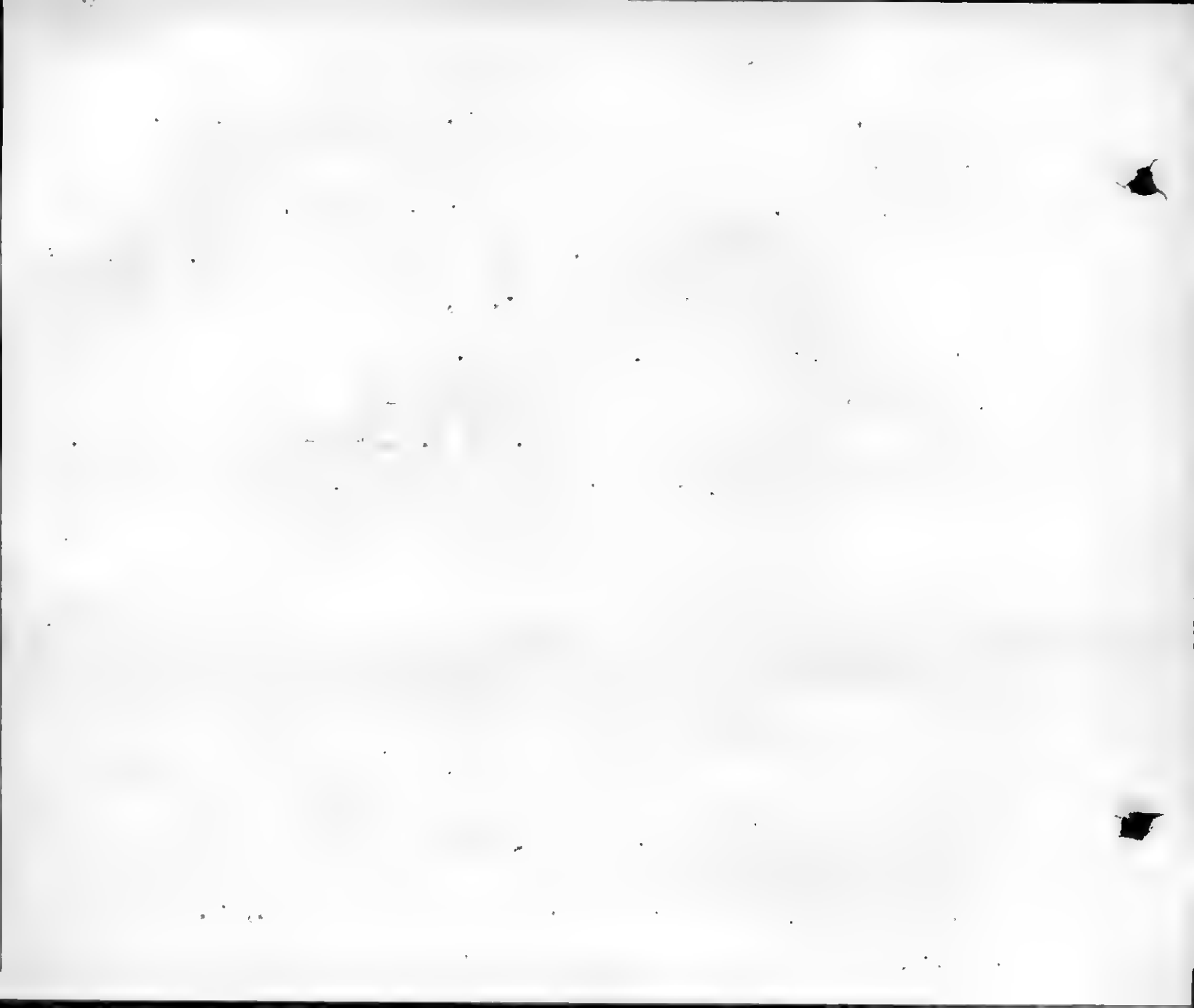
11108

11135

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1919 Rockwell Ave.</b>				e. STREET ADDRESS <b>1919 Rockwell Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHRISTOPHER</b> Middle <b>J.</b> Last <b>MCCORMICK</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1882</b>		9. AGE (In years last birthday) <b>76 yrs</b>	10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Protection Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Ward</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Protection Officer</b>				13. FATHER'S NAME <b>John McCormick</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret -</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT Address <b>Mrs. Ella M. Clemens - 1919 Rockwell Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION - MASSIVE</b> 420.1 DUE TO <b>HYPERTENSIVE CV DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 YRS.</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>JAN</b> , 19 <b>58</b> , to <b>OCT. 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>OCT. 28</b> , 19 <b>59</b> , and that death occurred at <b>11:47 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John F. Schaefer</b>				ADDRESS (Street, city or town, state) <b>401 RANDOM ROAD</b>			
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER M.D. BALTO. 29 MD.</b>				DATE SIGNED <b>10/29/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kline</b>				ADDRESS <b>Balto 17</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11138

CERTIFICATE OF DEATH

Reg. Dist. No.

11109

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>10 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>3837 ROLAND AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELLEN</b> Last <b>MCINTOSH</b>		4. DATE OF DEATH Month <b>OCT</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min <b>93</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRACTICAL NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>VERNON A. MCINTOSH</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE RYAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardis</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 years</b> (c) <b>10 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-3-1949</b> to <b>10-29-1959</b> , that I last saw the deceased alive on <b>10-29-1959</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter J. Cook</b>		DATE SIGNED <b>10/29/59</b>	
PHYSICIAN'S NAME (Type) <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul St.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/31/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Hampden</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. L. Smith Jr.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11137

## CERTIFICATE OF DEATH

11110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 Farview Court</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>H.</b> Middle <b>Ashby</b> Last <b>McVeigh</b>				4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1904</b>		9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. McVeigh</b>				14. MOTHER'S MAIDEN NAME <b>Maude Ashby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lora Marie McVeigh, 102 Farview Court, Timonium, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of lungs with metastases</b> DUE TO <b>Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1st, 1959</b> to <b>Oct 15, 1959</b> that I last saw the deceased alive on <b>Oct 15th, 1959</b> and that death occurred at <b>9</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3033 W. North A</b> DATE SIGNED <b>Paul Byerly</b>							
ACTUAL SIGNATURE <b>Paul Byerly</b>		M.D. <b>Paul Byerly</b>					
PHYSICIAN'S NAME (Type) <b>M Paul Byerly</b>		<b>Balto Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. C. Cook-Towson, Inc., 1050 York Road, Towson</b>				24a. REC'D BY REGISTRAR <b>OCT 19 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

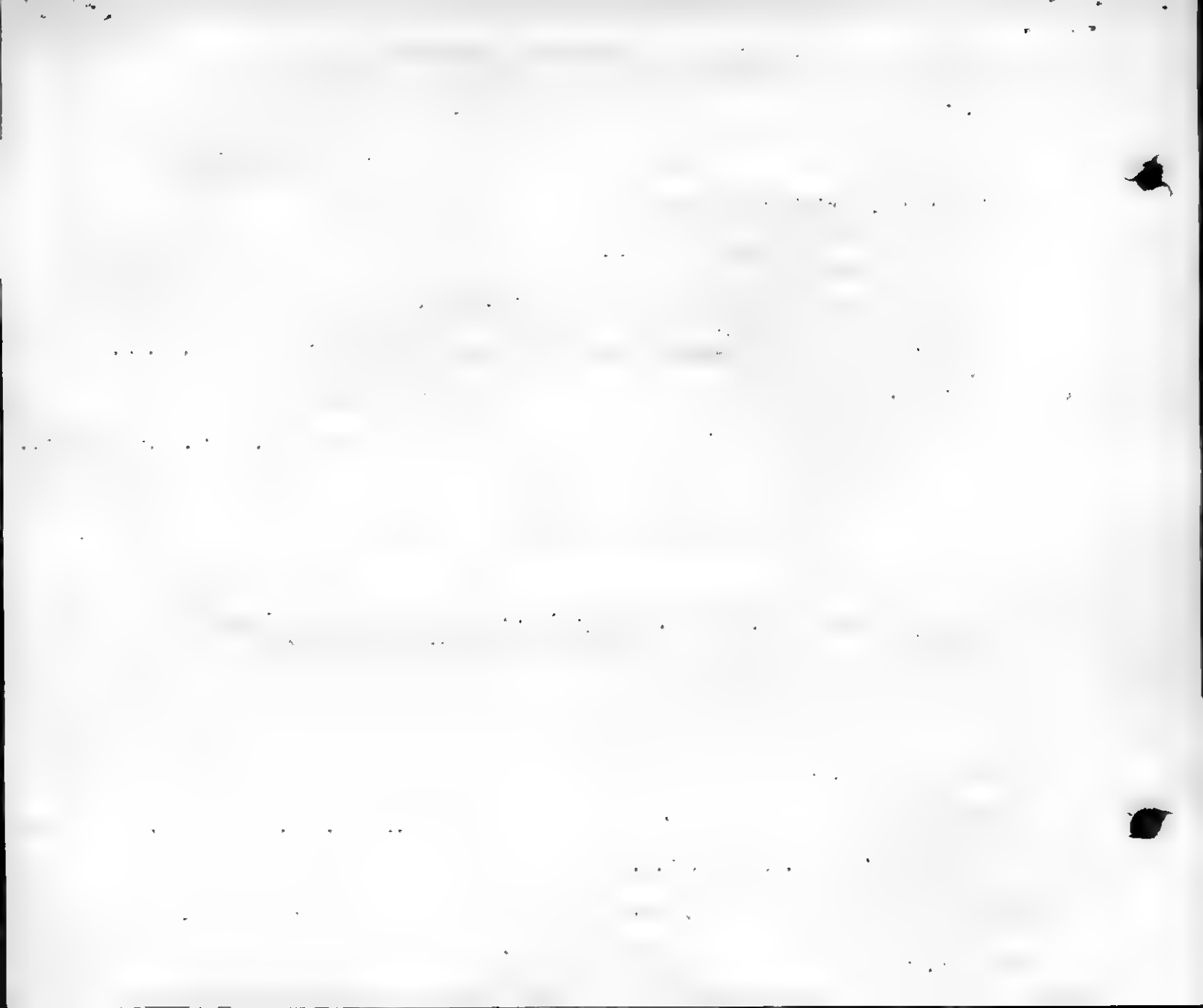
11111

11138

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>41 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(3512 Hillsmere Road) Baltimore, Maryland</b> c. STREET ADDRESS <b>3512 Hillsmere Road (7)</b> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH MEIER</b>		4. DATE OF DEATH Month Day Year <b>October 15 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1877</b>
9. AGE (In years last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min. <b>82</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sale of Vegetables</b>	
13. FATHER'S NAME <b>George F. Meier</b>		14. MOTHER'S MAIDEN NAME <b>Hester MN: Unknown Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>SAW</b>		INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER</b> <b>RECTOR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF RECTUM</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		Operations: TUR- Carcinoma of Bladder & Excision of Carcinoma of Rectum-9/18/59	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 4, 1959</b> to <b>October 15, 1959</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD., FT. HOWARD DIV. 10/15/59</b>			
ACTUAL SIGNATURE <b>Lawrence D. Marcus</b>			
PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11139

## CERTIFICATE OF DEATH

Reg. Dist. No.

11112

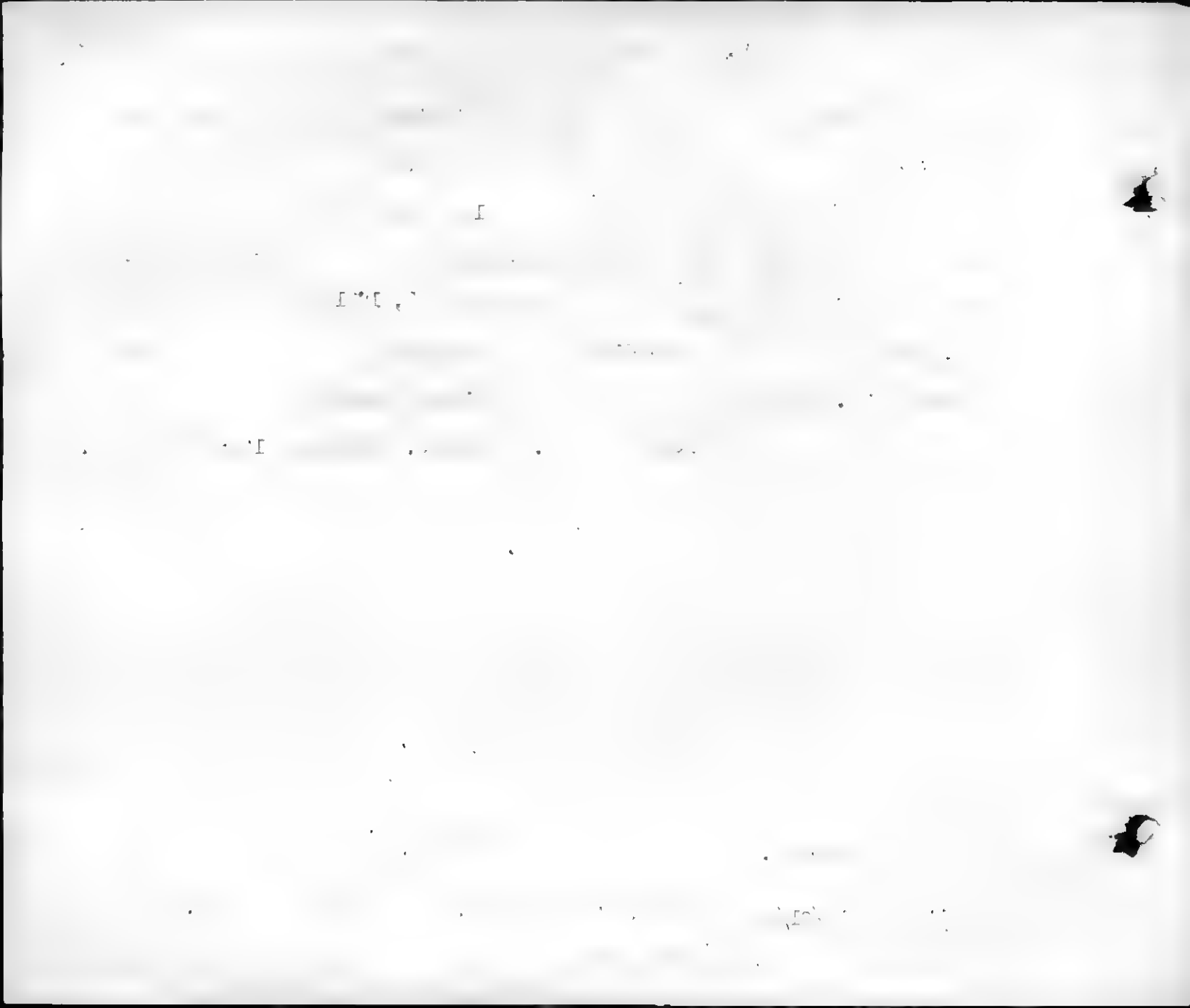
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V-1-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>		d. STREET ADDRESS <u>Roland Park Apts.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEILA REID MENDEL MENGEL</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 29, 1959 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 19, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ossac Mengel</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Probasco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Frank Primrose</u>		Address <u>Pikesville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov - 19 38</u> to <u>Oct 19 59</u> that I last saw the deceased alive on <u>Nov 19 38</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. <u>October 29</u> ACTUAL SIGNATURE <u>W. S. Weatherbee Fort</u> M.D. <u>1118 St. Paul St - Balt. Md</u> ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>
22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons, Inc., 1900 Eutaw Place</u>	
24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11141

## CERTIFICATE OF DEATH

11114

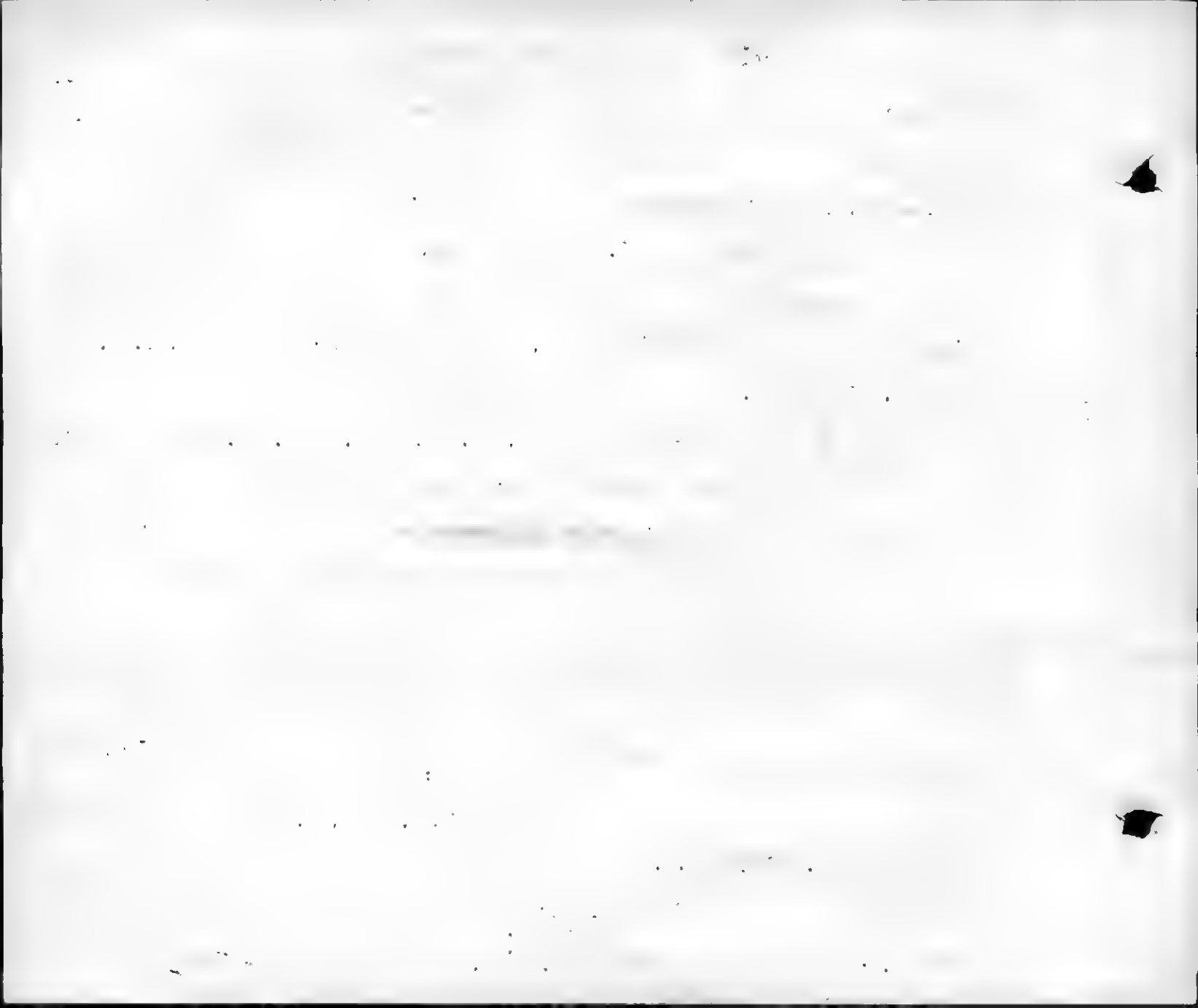
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>280 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Saint Michaels</b> d. STREET ADDRESS <b>Box 432</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>H.</b> Last <b>MILLER, JR.</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1913</b>
9. AGE (In years last birthday) <b>46</b>		10. IF UNDER 1 YEAR Months <b>46</b>	11. IF UNDER 24 HRS. Days <b>46</b> Hours <b>46</b> Min. <b>46</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings-Interior and Ext.</b>	
11. BIRTHPLACE (State or foreign country) <b>Saint Michaels, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles H. Miller, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hopkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>230-05-9838</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>		Address <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, RIGHT UPPER LOBE</b> DUE TO 716X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CACHEXIA</b> DUE TO <b>MALABSORPTION</b> DUE TO <b>TOPIGMENTATION AND EDEMA OF THE MUCOSA OF SMALL BOWEL</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>18 MONTHS</b> <b>18 MO</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 29, 1958</b> to <b>October 5, 1959</b> and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION 10/6/59</b>			
ACTUAL SIGNATURE <i>N. L. Newton</i>		M.D. <b>NORRIS L. NEWTON, M.D.</b>	
22a. BURIAL, CREMATION, or MOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chas F. Thomas Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Saint Michaels, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		24a. REC'D BY REGISTRAR <b>OCT 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arlington S. Phillips</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

Shipped to James B. Dashiell, Easton, Maryland



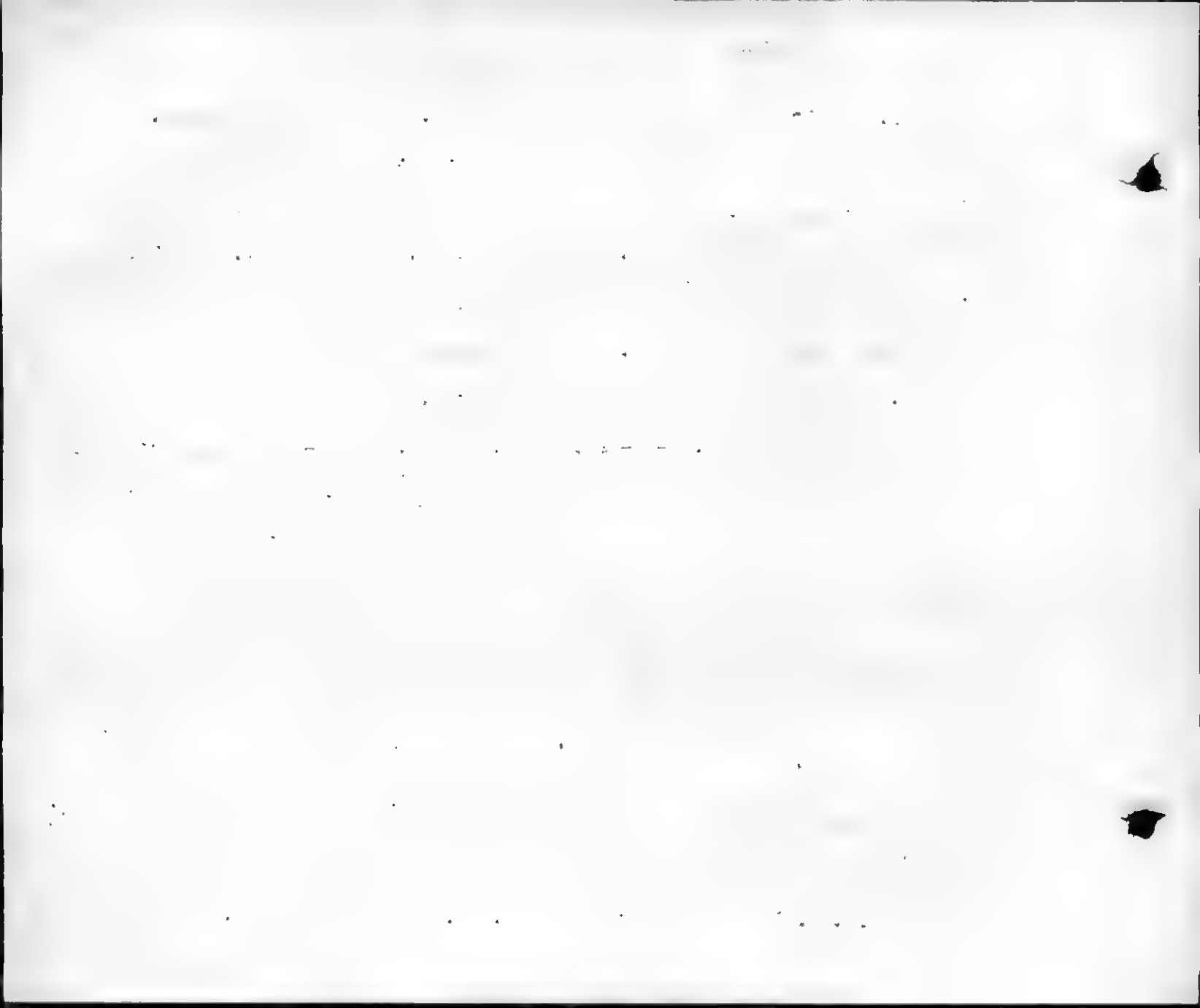
11142

## CERTIFICATE OF DEATH

11115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2511 Lodge Forest Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>J.</b> Last <b>MILLER, SR.</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1922</b>	
9. AGE (In years lost birthday) <b>37 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heater Helper</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Randall R. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Bertha J. Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>417-20-7196</b>			
17. INFORMANT <b>Mrs. Anna A. Miller-2511 Lodge Forest Drive</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>425.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>One-half hour</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>July 1, 1958</b> to <b>Oct 20, 1959</b> that I last saw the deceased alive on <b>Oct 20, 1959</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John V. Conway, M.D.</b>				ADDRESS (Street, city or town, state) <b>914 D St., Balt. 19, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Oct. 22, 1959</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10.23.59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Wickner</b>				24a. REC'D BY REGISTRAR <b>OCT 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneen</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11143

## CERTIFICATE OF DEATH

## 11116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>2005 Kennedy Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Cecilia</u> Middle <u>Miller</u> Last		4. DATE OF DEATH <u>Oct.</u> Month <u>2</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rudolf Von Bussenius</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia F. Biedermann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Elmer G. Miller, 2005 Kennedy Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> 19 <u>59</u> , to <u>Oct.</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 28, 19 59</u> , and that death occurred at <u>6:38</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>Oct. 2, 1959</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>OCT 5 2 '59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Charles A. Kline</u>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11144

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm'ssion) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b>		c. LENGTH OF STAY IN 1b <b>X STEVENSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VILLA JULIE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SISTER MARIE MONICA (MARY NEEDHAM)</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 9, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR: Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFORMARIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	
11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES NEEDHAM</b>		14. MOTHER'S MAIDEN NAME <b>ANN McDONOUGH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Sister Mary Patricia Villa Julie</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <b>Coronary Renal Vascular disease.</b> DUE TO (b) <b>arterio sclerosis &amp; mental deterioration</b> DUE TO (c) <b>age.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>54</b> , to <b>Oct 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 8</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Harold H Burns</b>		ADDRESS (Street, city or town, state) <b>115 E. Capital St.</b>	
PHYSICIAN'S NAME (Type) <b>Harold H. Burns</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>10-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Convent Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Thebes, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home - Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. J. K. K.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 11145 CERTIFICATE OF DEATH

Reg. Dist. No. 32

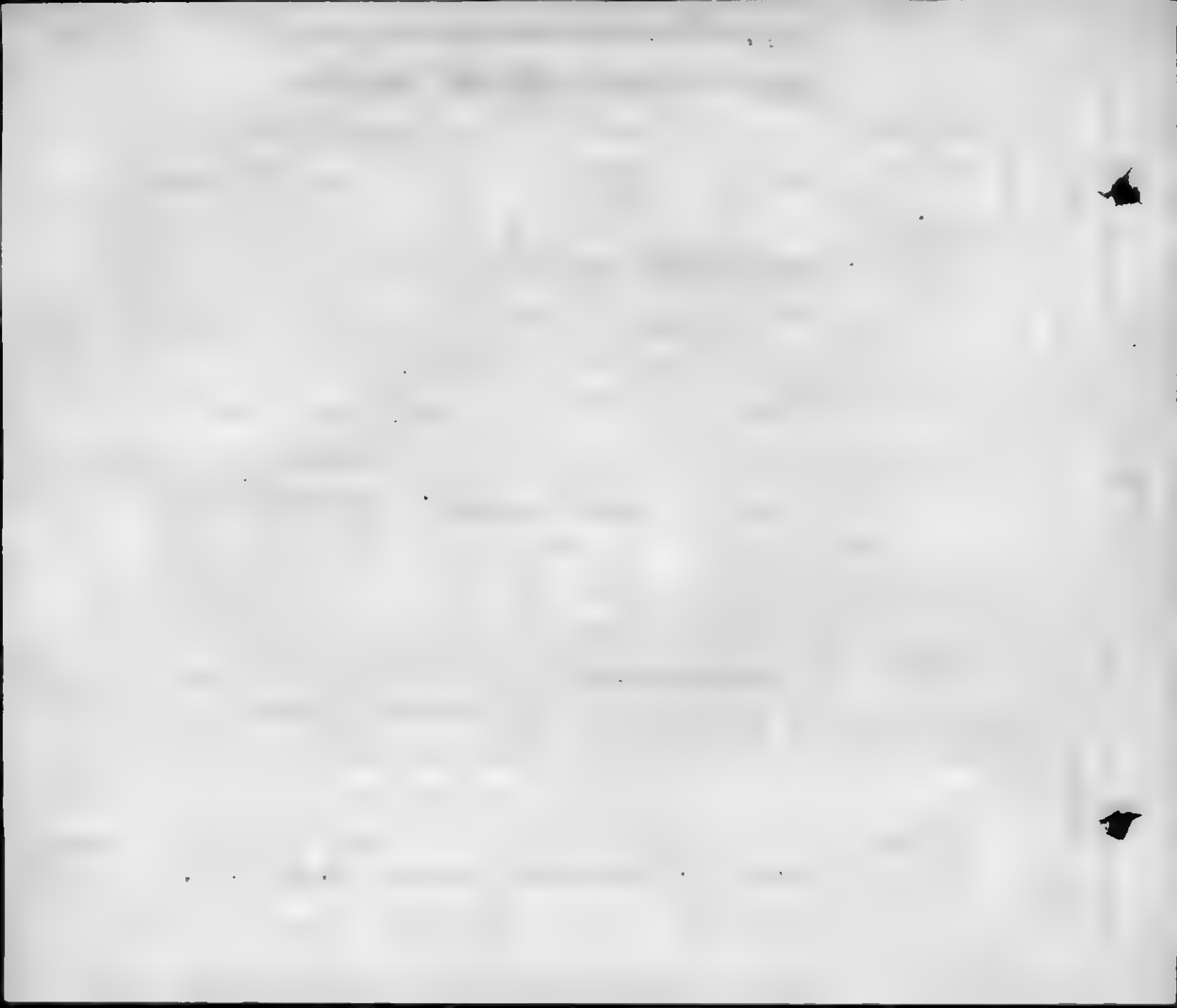
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>8 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>MAPLE AVENUE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LOYD LEONARD MORRIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 26 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>9/29/96</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RURAL LETTER CARRIER - RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN IRVIN MORRIS</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE E LLOYD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>YES</u> (If Yes, give war or dates of service) <u>WW II</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCT</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY THROMBOSIS</u>						<u>unusual</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO SCLEROTIC CARDIAC DISEASE</u>						<u>24 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PULMONARY TUBERCULOSIS</u>						<u>1 1/2 years</u>	
19a. DATE OF OPERATION <u>002.X</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/13</u> , 19 <u>57</u> , to <u>10/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/26</u> , 19 <u>57</u> , and that death occurred at <u>11:40</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcome M.D. Superintendent, Mt. Wilson, Md.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>10-27-57</u>		NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u>		LOCATION (City, town, or county) (State) <u>Trappe, Talbot Co., Md.</u>	
24. REC'D BY REGISTRAR <u>OCT 30 59</u>		REGISTRAR'S SIGNATURE <u>William D. Newcome</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William D. Newcome</u>		ADDRESS <u>Trappe, Md.</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11146 CERTIFICATE OF DEATH

Reg. Dist. No. **11119**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>61 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X2</b>			
f. STREET ADDRESS <b>3014 Dent Place, N.W.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>LOUIS</b> Last <b>MORTFELD</b>				4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1891</b>	9. AGE (In years last birthday) <b>68</b> yrs	IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patrolman (Civilian)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army Engineers</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert L. Mortfeld</b>				14. MOTHER'S MAIDEN NAME <b>Sophia</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO <b>578-05-0506</b>			
17. INFORMANT <b>Clin. Rec. VAH Balto 18 Md, Ft Howard Division</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>163X</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA OF LUNG</b> DUE TO				<b>6 mos.</b>			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>Residual thrombosis, left middle cerebral artery</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <b>VA</b> attended the deceased from <b>August 18, 1959</b> , to <b>October 18, 1959</b> , and that death occurred at <b>1:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence D. Marcus</b>				ADDRESS (Street, city or town, state) <b>M.D. VAH Balto 18 Md., Ft. Howard Div.</b>		DATE SIGNED <b>OCT 20 '59</b>	
PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.K. Huntemann &amp; Son, Inc. Wash.</b>				24a. REC'D BY REGISTRAR <b>OCT 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hayes</b>	

W.K. HUNTEMANN & SONS, 5732 Georgia Ave., NW, Wash., D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

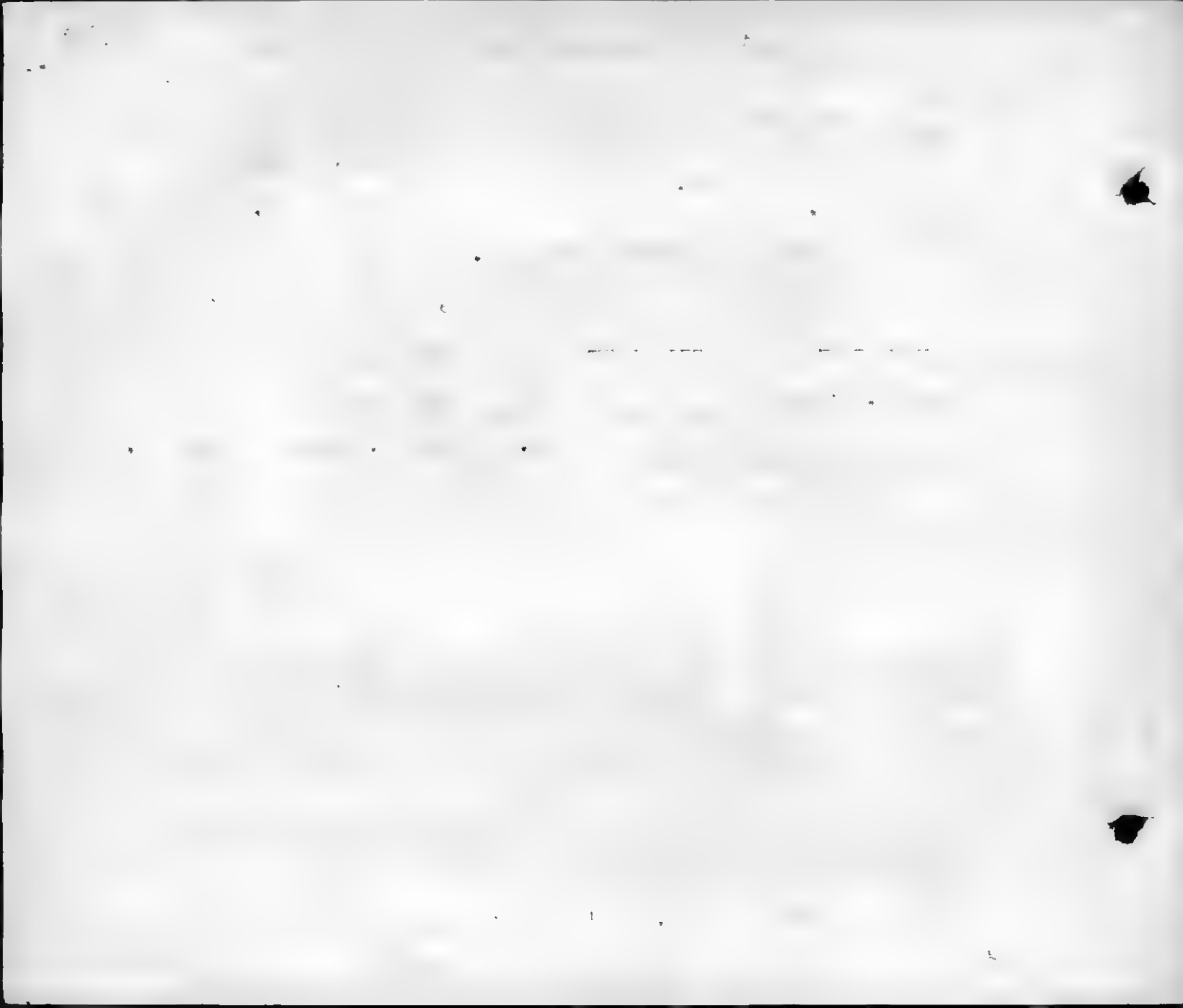
11120

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>115 Tenbury Rd.</b>		d. STREET ADDRESS <b>115 Tenbury Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas Campbell Murray Jr.</b>		4. DATE OF DEATH Month <b>10</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1957</b>
9. AGE (In years last birthday) <b>2 yrs. 3</b>		IF UNDER 1 YEAR Days <b>3</b> IF UNDER 24 HRS Hours <b>3</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Thomas C. Murray</b>		14. MOTHER'S MAIDEN NAME <b>Julia Codd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Catherine T. Murray</b>		Address <b>5220 York Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> <b>Child fell into area of stream beneath road had one spot 3 ft deep his mother found him there face down.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I and in 18b)	
20c. TIME OF INJURY Month <b>10</b> Day <b>10</b> Year <b>1959</b> Hour <b>12:45</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>Street</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's, Govans</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. V. Means &amp; Son - 805 N. Calvert St.</b>		24a. REC'D BY REGISTRAR <b>OCT 14 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 11024 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

11121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>	
c. LENGTH OF STAY IN 1b <u>4 Months</u>		d. STREET ADDRESS <u>--</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Relay Hill Hospital, Relay, 27, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penna. R.R. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Odenton, A.A. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph D. Meyers</u>		14. MOTHER'S MAIDEN NAME <u>Emma Meeks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>717-07-5946</u>	
17. INFORMANT <u>Wife: Mary Beasley Myers, Odenton, A.A. Co., Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>--</u>		INTERVAL BETWEEN ONSET AND DEATH <u>60 hours</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>58</u> , to <u>October 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>October 6</u> , 19 <u>59</u> , and that death occurred at <u>7:12 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>196/59</u>			
ACTUAL SIGNATURE <u>Lewis P. Gundry</u> M.D.		PHYSICIAN'S NAME (Type) <u>Lewis P. Gundry, M.D. Relay, 27, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10 October 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Jalton &amp; Thana</u>			





1  
X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11148

CERTIFICATE OF DEATH

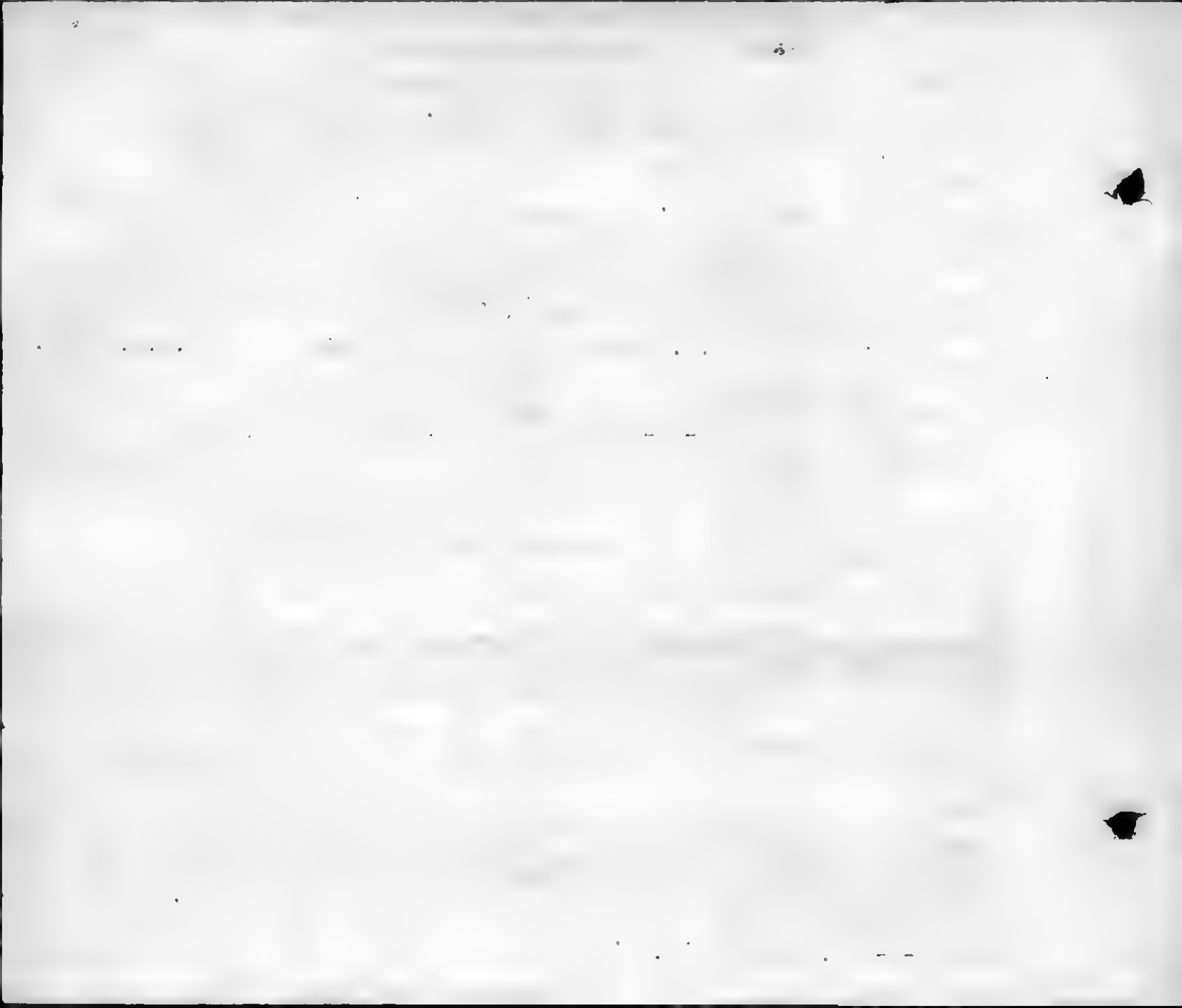
11122

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4515 Fullerton Ave.</b>		d. STREET ADDRESS <b>4515 Fullerton Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>NEBOHY</b> Last		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>T. I. Swartz</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>
12. CITIZEN OF WHAT COUNTRY? <b>Czech.</b>			
13. FATHER'S NAME <b>John Nebohy</b>		14. MOTHER'S MAIDEN NAME <b>Antonia Bukovsky</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-09-23044</b>	
17. INFORMANT <b>Lillian Jesatko, dght, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-26-16</b> , 19 <b>54</b> , to <b>Oct. 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 21</b> , 19 <b>59</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Adam G. Swiss</b>		ADDRESS (Street, city or town, state) <b>6732 Belair Rd, Balto. 6</b>	
PHYSICIAN'S NAME (Type) <b>ADAM G. SWISS</b>		DATE SIGNED <b>Oct 23 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 26 '59</b>	
ADDRESS <b>2601-3-5 E. Madison St.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

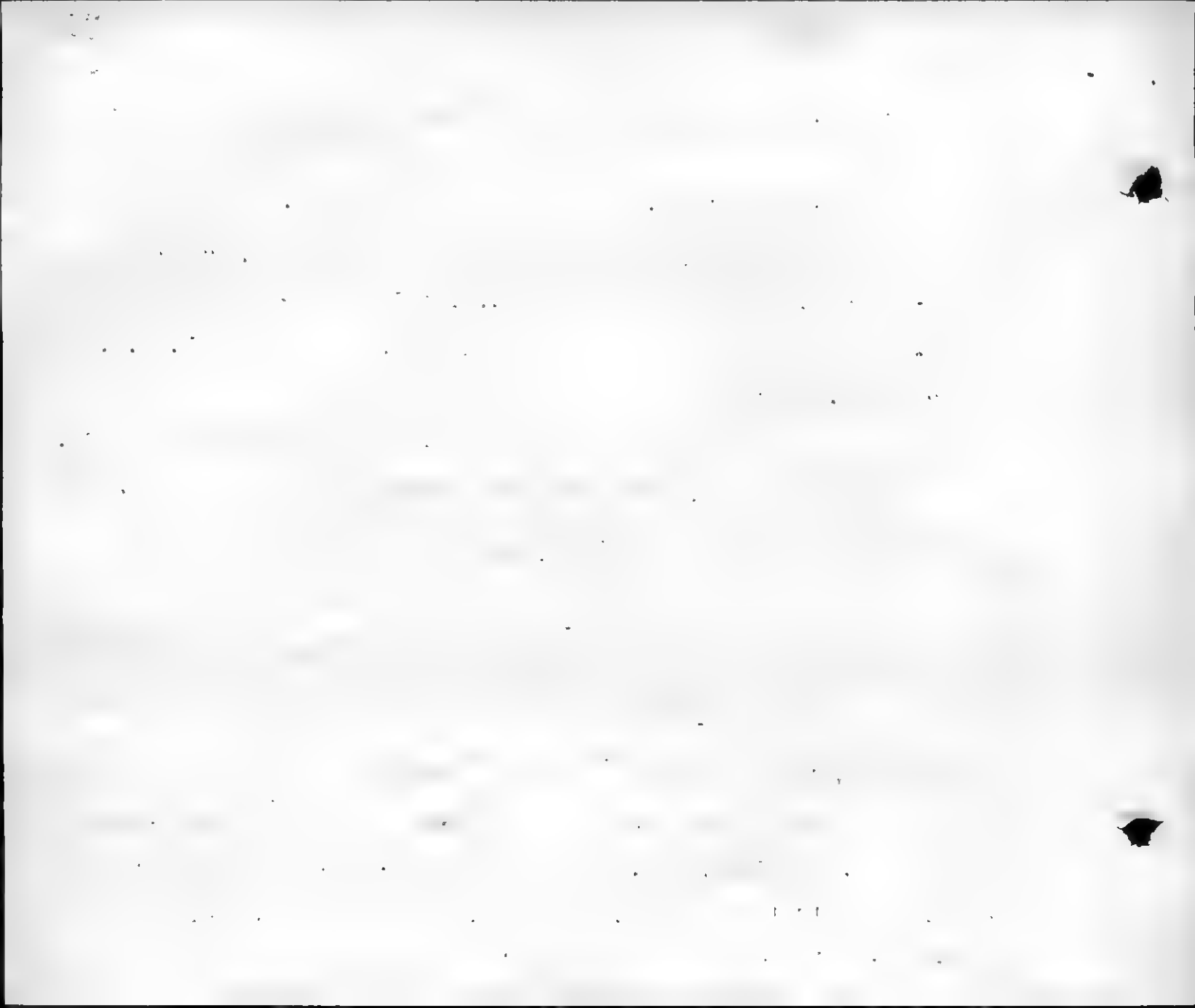


11149 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

11123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5543 Gayland Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Malinda Neighoff</b>		4. DATE OF DEATH Month Day Year <b>Oct. 24, 1959 19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>	
13. FATHER'S NAME <b>Charles S. Neighoff</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Dibbs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Bernard N. Neighoff 5543 Gayland Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>_____</b> DUE TO (c) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1959</b> to <b>Oct 24, 1959</b> that I last saw the deceased alive on <b>Oct 24, 1959</b> and that death occurred at <b>4001 Wilkens Ave Baltimore Md</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>I. Earl Pass</b> M.D.		DATE SIGNED <b>Oct 26 1959</b>	
PHYSICIAN'S NAME (Type) <b>I. Earl Pass, M.D.</b>		<b>4001 Wilkens Avenue #29</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louder Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Howard H. Hubbard 4107 Wilkens Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kinross</b>	



11150 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

11124

1. NAME OF DECEASED  
 (Type or Print)

EFFIE ENGLEMAN NELSON

2. DATE OF DEATH  
 October 23, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland  
 B. FULL NAME OF HOSPITAL OR INSTITUTION  
 2226 Southland Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
 A. STATE Maryland  
 B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
 Baltimore

D. STREET ADDRESS (If rural, give location)  
 2226 Southland Road #7

5. SEX  
 Female

6. COLOR OR RACE  
 White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
 Widowed

8. DATE OF BIRTH  
 March 28, 1874

9. AGE (In years last birthday)  
 85

If Under 1 Year If Under 24 Hours  
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
 Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
 Ohio

12. CITIZEN OF WHAT COUNTRY?  
 U.S.A.

13. FATHER'S NAME

Eden Engleman

14. MOTHER'S MAIDEN NAME

Eliza Nicodemus

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  
 No

16. SOCIAL SECURITY NO.  
 None

17. INFORMANT ADDRESS  
 Miss Mary Nelson-2226 Southland Road #7

18.

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

I  
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cardiovascular*

*5 min*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Coronary Thrombosis*

*15 minutes*

(C)

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

2D. AUTOPSY?

21B. TIME (Month) (Day) (Hour) (Minute) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

yes ☐ no ☐

22. I certify that (I) (this hospital) attended the deceased from *Oct 23* 19*59*, that (I) (we) last saw the deceased alive on *Oct 23* 19*59*, and that in (my) (our) opinion death occurred at *9 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. M.D.

*1138 North Bayview*

*Oct 28/59*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10/26/59 Spring Grove Cemetery

Cincinnati, Ohio

DATE RECEIVED BY REGISTRAR  
 OCT 24 1959

REGISTRAR'S SIGNATURE

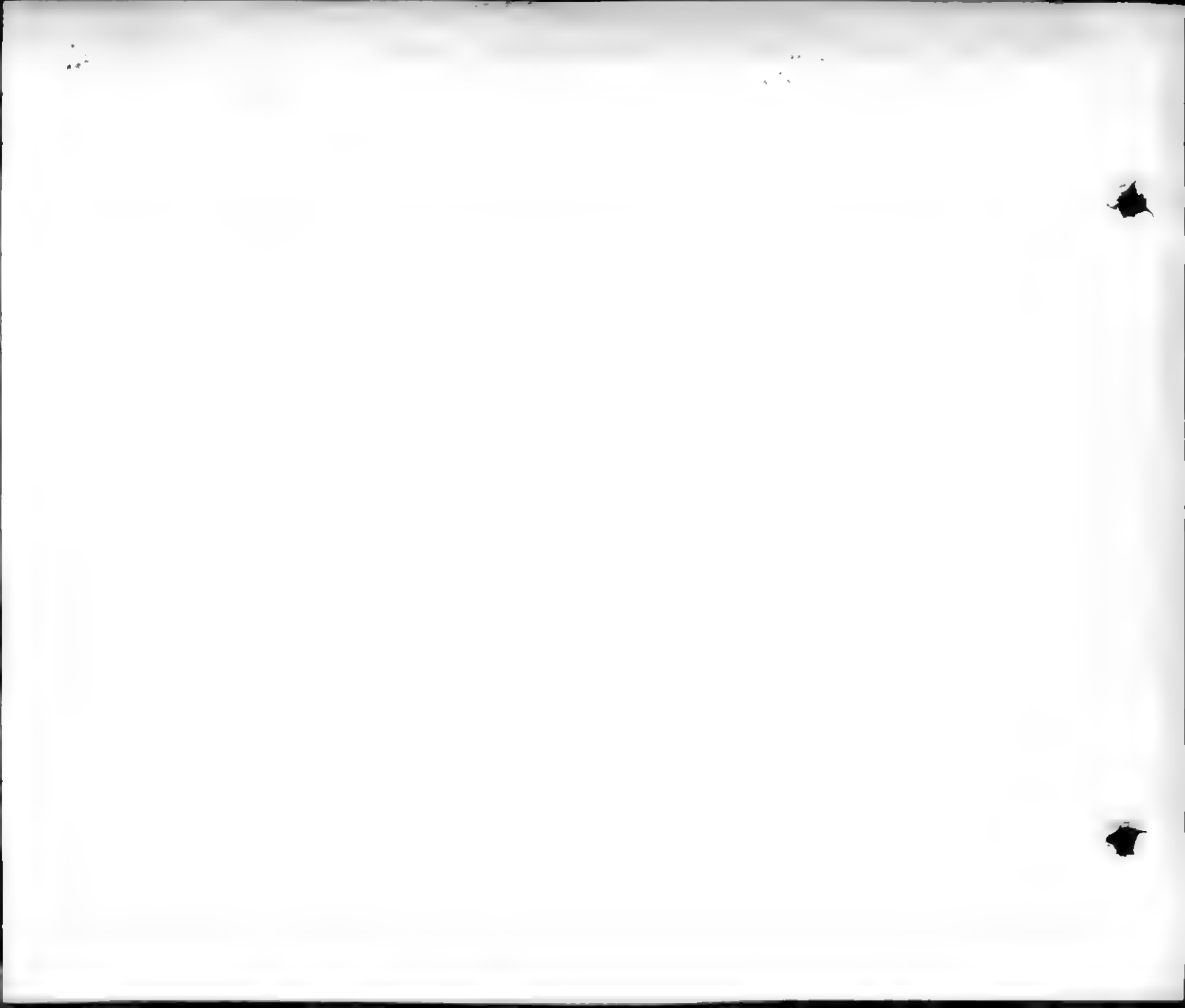
25. FUNERAL DIRECTOR

ADDRESS

*Huntington Hills, Md. Wm. J. T. Weber*

THIS IS A PERMANENT RECORD

PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN Every item of information should be fully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER D



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11125

11151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>833 KINGSTON RD</u>		d. STREET ADDRESS <u>1833 KINGSTON RD</u>	
3. NAME OF DECEASED (Type or print) <u>GRACE MARGARET NESBITT</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16-1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mins.	IF UNDER 24 HRS Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>office work</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HARRY STEFFLEY</u>		14. MOTHER'S MAIDEN NAME <u>IDA BARKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-12-8750</u>	
17. INFORMANT <u>L. Meade Nesbitt</u>		Address <u>833 KINGSTON RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4 x 10.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> to <u>4 Oct.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Oct.</u> , 19 <u>59</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Vieg</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>6701 York Rd Baltimore Md - Oct 19</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u>		ADDRESS <u>5209 YORK RD</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arline E. Kraus</u>	





11152

CERTIFICATE OF DEATH

11126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cub Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cub Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2914 Northwind Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First <u>Neubert</u> Middle <u>Neubert</u> Last		4. DATE OF DEATH <u>Oct</u> Month <u>9</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 9 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Oh. O</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-10-3026</u>	
17. INFORMANT <u>Chas F. Neubert</u> Address <u>5 AMR</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Adam's Stokes Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Arteriosclerotic Vasc. dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>15 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 8</u> 19 <u>59</u> to <u>Oct 10</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 19</u> 19 <u>59</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above			
ACCEDEE'S SIGNATURE <u>Frank T. Kasik Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Hartford Rd Balto 14 Md</u>	
PHYSICIAN'S NAME (Type) <u>F.T. KASIK JR</u>		DATE SIGNED <u>10/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT-12-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VA 2 KNOX</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS &amp; Son</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Clifton A. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11016

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus 51</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1142 Linden Ave</b>		d. STREET ADDRESS <b>1142 Linden Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>L.</b> Last <b>Neuendorf</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buffer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Radiator</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Neuendorf</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213 01 4340</b>	
17. INFORMANT <b>Mrs. Agnes Neuendorf</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 25, 1955</b> to <b>October 13, 1959</b> , that I last saw the deceased alive on <b>February 21, 1959</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Melvin N. Borden</b> M.D. <b>5000 BALTO NATIONAL PIKE</b> ACTUAL SIGNATURE <b>Melvin N. BORDEN</b> <b>BALTO 29, MD</b> <b>10/15/59</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn 7, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b> <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 19 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATION

CORONARY THROMBOSIS

MON

February 21 1974  
11:00 AM

William J. Borden

2000 BALTO NATIONAL PIKE

BALTO 21, MD

10/12/74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

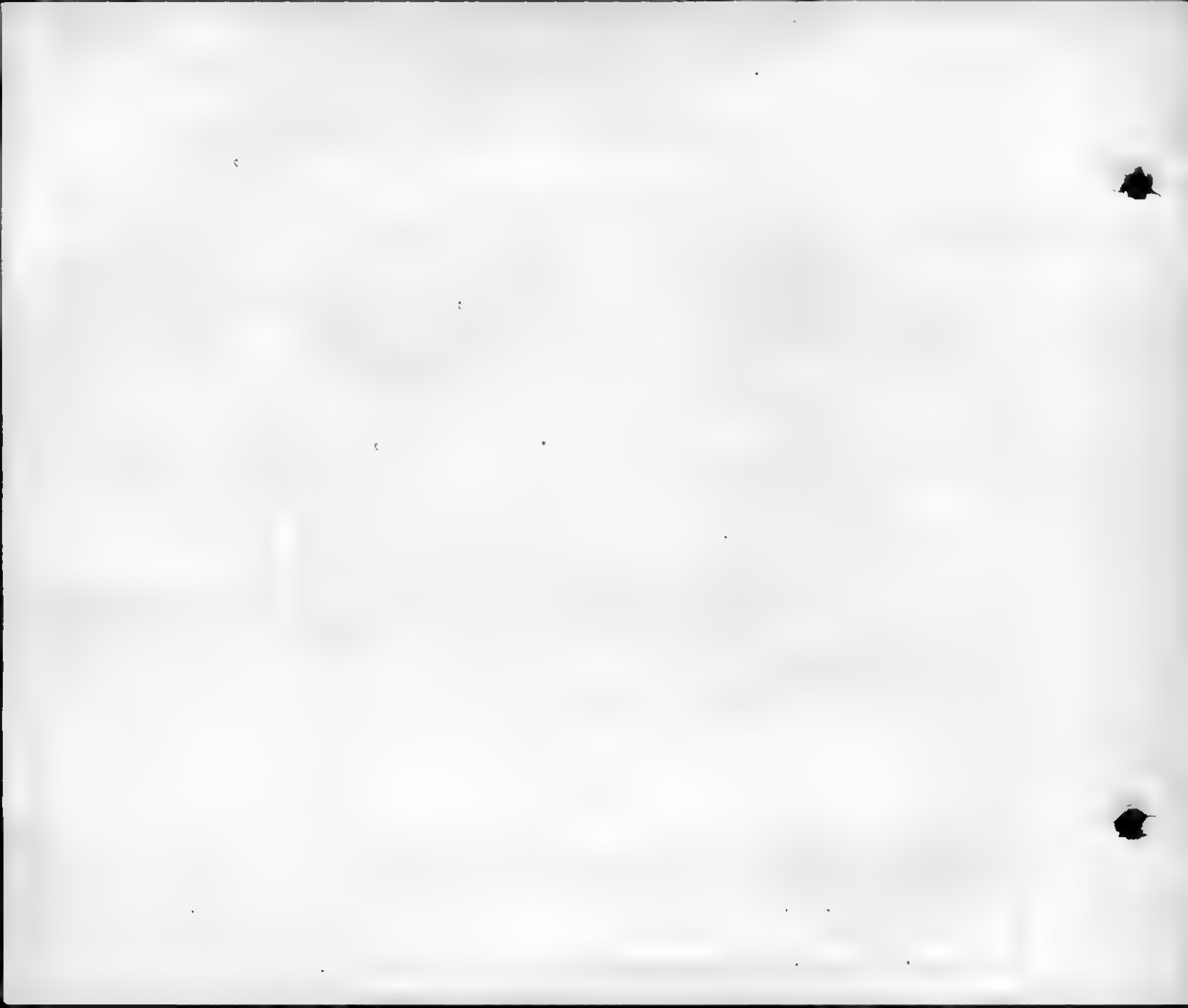
11153

## CERTIFICATE OF DEATH

11123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>		c. LENGTH OF STAY IN ID <b>1 Yr</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6607 Greenspring Ave, Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Foxleigh Nursing Home</b>		d. STREET ADDRESS <b>6607 Greenspring Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Neuman</b> Last <b>Neuman</b>		4. DATE OF DEATH <b>Oct 11 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1887</b>	9. AGE (In years last birthday) <b>72</b> yrs	IF UNDER 1 YEAR: Months <b>3</b> Days <b>2</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
13. FATHER'S NAME <b>Moses Daniel</b>		14. MOTHER'S MAIDEN NAME <b>Henny Jansdorf</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Joan Miller, 6607 Greenspring Av</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Stomach</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>8 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. p.</b> Month <b>19</b> Day <b></b> Year <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1958</b> , 19 <b></b> , to <b>10/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/11</b> , 19 <b>59</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Edward P. Haller</b>		ADDRESS (Street, city or town, state) <b>4307 Mount Airy Dr Baltimore Md</b>			
PHYSICIAN'S NAME (Type) <b>David R. Martin</b>		DATE SIGNED <b>10/11/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew Cem</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 15 59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Klaus</b>	



11017

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2708 Tilden Rd.</b>		d. STREET ADDRESS <b>2708 Tilden Rd.</b>	
3. NAME OF <b>BARBARA</b> (Type or print) First <b>Barbara</b> Middle <b>Noyes</b> Last		4. DATE OF DEATH <b>Oct. 8, 1959</b> Month <b>Oct.</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 29, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Nichol</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Mueller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <b>Theresa Tracey-2708 Tilden Rd.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CA of Cervix with Metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>to Liver, Brain etc</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1956</b> to <b>Oct 8, 1959</b> , that I last saw the deceased alive on <b>Oct. 7, 1959</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. B. Davis</b>		ADDRESS (Street, city or town, state) <b>6800 MORNINGTON Rd</b> DATE SIGNED <b>10/9/59</b>	
PHYSICIAN'S NAME (Type) <b>M. B. DAVIS M.D.</b>		<b>Dundalk - 2708 Tilden Rd</b>	
22a. BURIAL, CREMATION, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-12-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Miller Inc - 2431 E. Oliver St.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11154

## CERTIFICATE OF DEATH

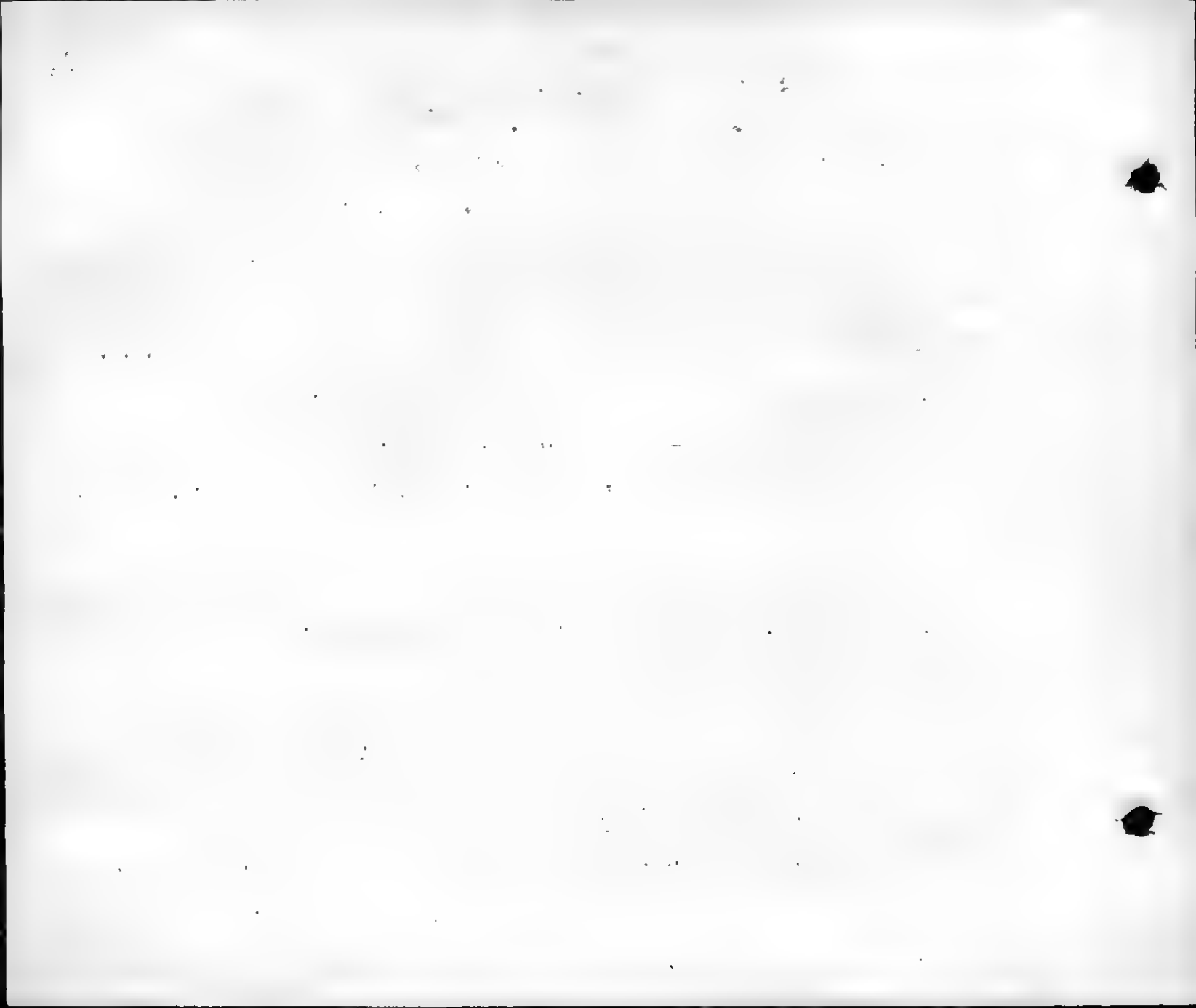
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. STREET ADDRESS <b>903 East Lombard Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Vonnie</b> Middle <b>May</b> Last <b>Oxendine</b>		4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/59</b>
9. AGE (in years last birthday) yrs. <b>7</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b>	11. IF UNDER 24 HRS Hours <b>15</b> Min <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry B. Oxendine</b>	
14. MOTHER'S MAIDEN NAME <b>Sadie May Sampson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. ADDRESS <b>Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastroenteritis - acute - etiology undetermined.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prolapsed rectum</b> DUE TO (c) <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arnold Chiari Syndrome (hydrocephalus, spina bifida and meningocele)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>9/8/59</b> , 19 <b>59</b> , to <b>10/15/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 17th</b> , 19 <b>59</b> , and that death occurred at <b>1:20 p.m.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Harry G. Butler</b> M.D.		ADDRESS (Street, city or town, state) <b>1157</b> DATE SIGNED <b>10/15/59</b>	
PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>		Rosewood Lane, Owings Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>OCT 17 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT CARMEL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>ODONNELL ST MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Bro 1800 E Lombard St</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 19 59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Kneass</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2033266XV4



11131

## 11155 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto. City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		LENGTH OF STAY (In this place) <u>15 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>307 N. Broadway</u>			
3. NAME OF DECEASED (Type or Print) <u>Thomas D. Pachel</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 6 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>1/15/1890</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Don Pachel</u>				14. MOTHER'S MAIDEN NAME <u>Jeann ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>208-10-9567</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Aneurysm of Abdominal Aorta</u>						<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Far Advanced Pulmonary Tuberculosis</u>						<u>1940</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>C2X</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/8</u> , 19 <u>58</u> , to <u>10/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/6</u> , 19 <u>59</u> , and that death occurred at <u>908 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-8-59</u>		NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn 7</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11132

11156  
**CERTIFICATE OF DEATH**

Reg. Dist. No. ....

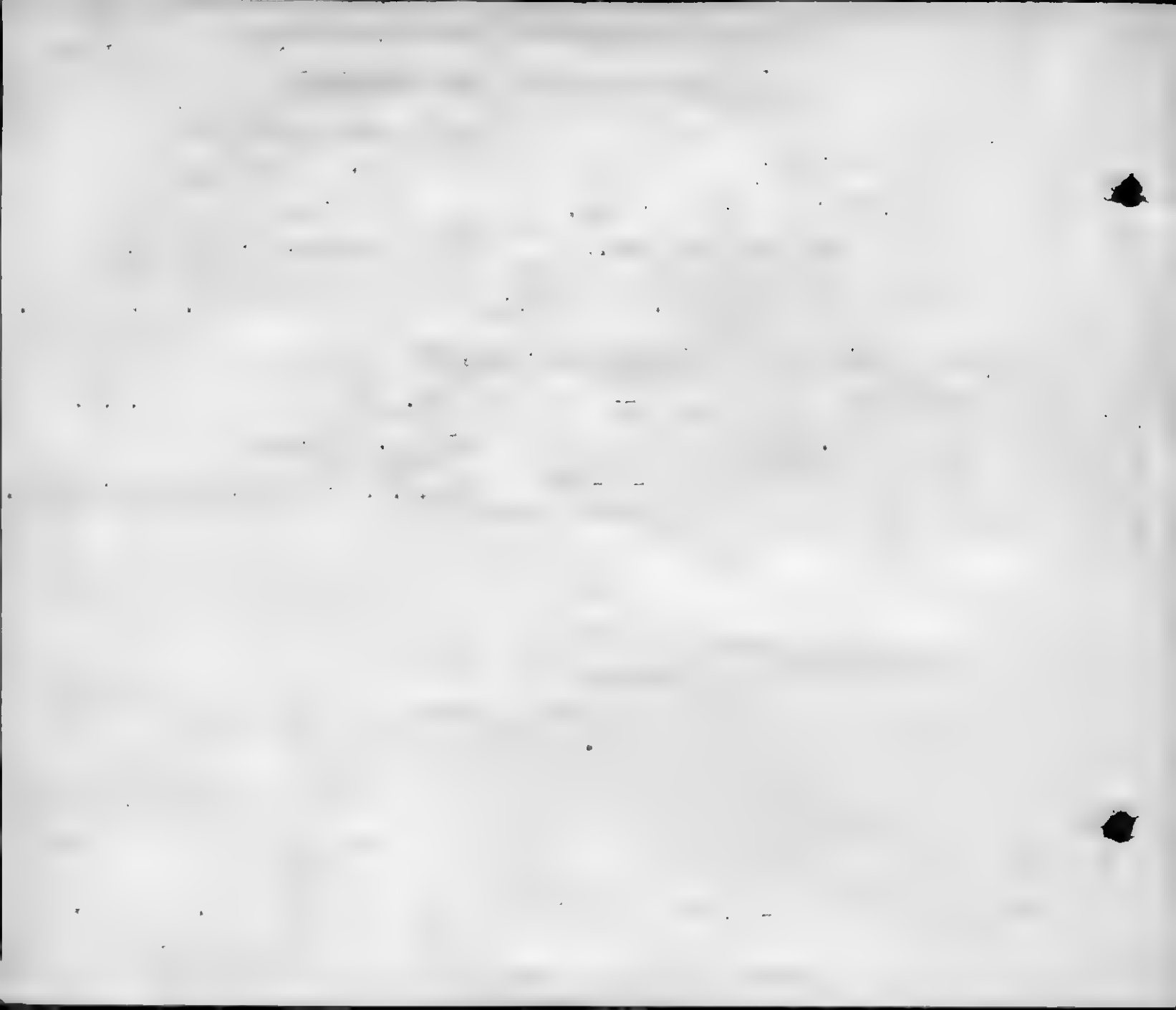
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Manor</b>		LENGTH OF STAY (In this place) <b>9 Mos.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
TOWN				STREET ADDRESS (If rural give location) <b>5100 Franklinton Road</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5903 Baltimore Ave.,</b>							
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>Ethel H. Parrish</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Oct. 30, 19 59.</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>March 13, 1895</b>		<b>9. AGE last birthday</b> <b>64</b> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.) <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if <b>Housewife</b> )		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>--</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Edward F. Gohr</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella A. Kidwell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-32-8834</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. T.A. Levering 5903 Baltimore A.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <b>Cerebral Vascular Accident</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertensive Cerebral Vascular Disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Diabetes Mellitus</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Chronic Nephritis - Uremic</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Oct 1, 19 59, to Oct 30, 19 59, that I last saw the deceased alive on Oct 30, 19 59, and that death occurred at 4:50 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Dr. Thor J. R. R. R.</i>		<b>M.D.</b> <i>4509 Liberty Hospital</i>		<b>DATE SIGNED</b> <i>10-31-59</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11-3-1959</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Park</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Woodlawn, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>John F. R. R.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>J. H. W. R. R.</i>		<b>ADDRESS</b> <i>3207 W. North St.</i>	
<b>DATE</b> <b>NOV 3 1959</b>							

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11157

## CERTIFICATE OF DEATH

11133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. LENGTH OF STAY IN TB <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>OVERHILL ROAD</b>		e. STREET ADDRESS <b>OVERHILL ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>WALTER C PARRISH</b>		4. DATE OF DEATH <b>Oct 23 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 9-1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES W PARRISH</b>		14. MOTHER'S MAIDEN NAME <b>EMMA TIMBERLAKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-01-3045</b>	
17. INFORMANT <b>ETHEL M PARRISH</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>7 yrs up</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 18, 1959</b> to <b>OCT. 23, 1959</b> , that I last saw the deceased alive on <b>OCT. 21, 1959</b> , and that death occurred at <b>4:24 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin L Pierpont</b>		ADDRESS (Street, city or town, state) <b>8704 LIGERTY RD, BALTO, MD</b>	
PHYSICIAN'S NAME (Type) <b>EDWIN L PIERPONT, MD</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LORPAINET PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William E Donovan</b>		ADDRESS <b>3808 Roland Ave</b>	
24a. REC'D BY REGISTRAR <b>OCT 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Wm S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

INSTRUCTIONS

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VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

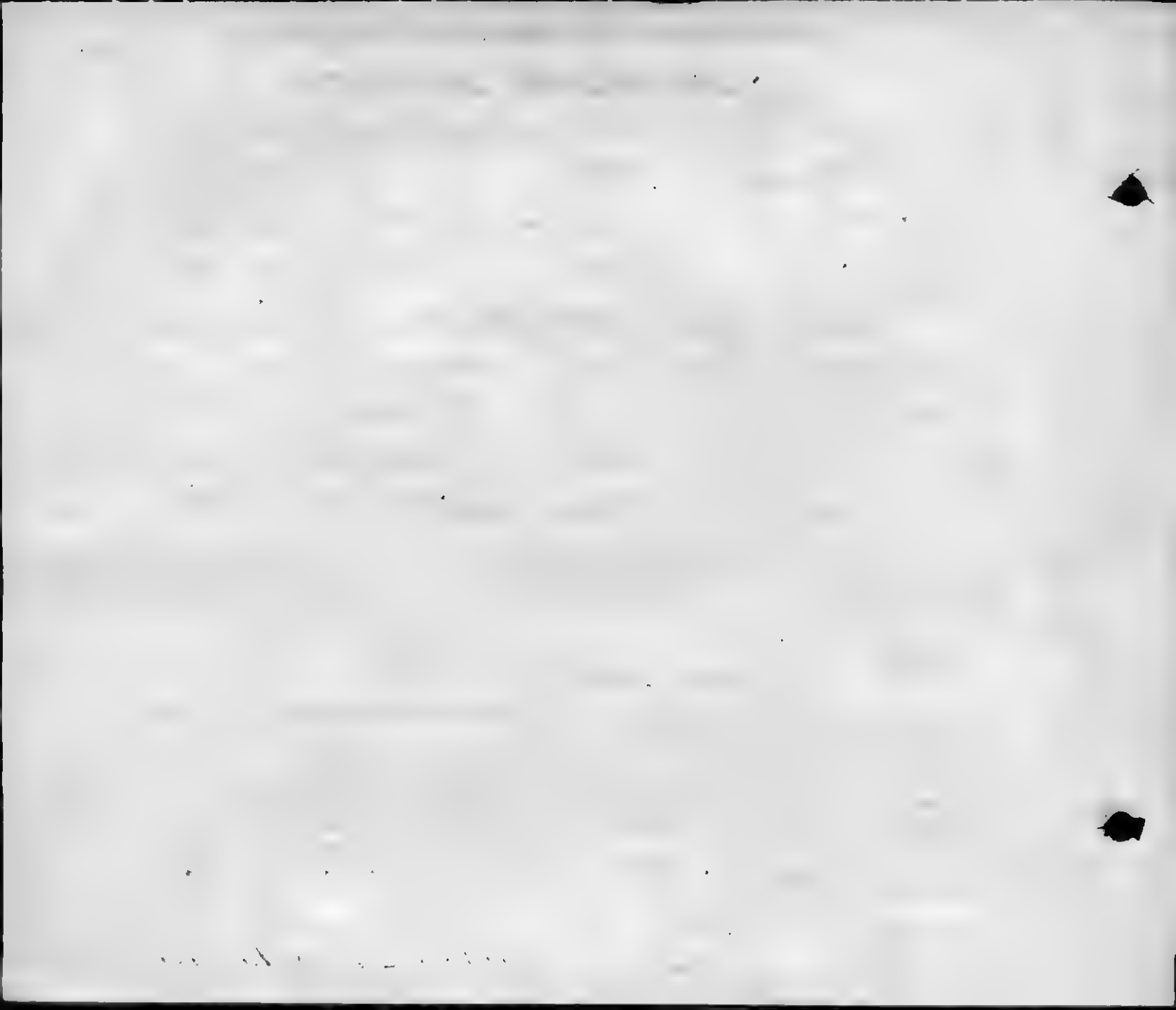
11134

Reg. Dist. No. 32

11158

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTIMORE CITY</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u> STREET ADDRESS <u>3429 Park Lawn Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>NETTIE</u> (Middle) <u>LOUISE</u> (Last) <u>PAUL</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>31</u> (Year) <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-19-97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY HUBER</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE/MOHR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-5550</u>	
17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>FAR ADVANCED PULMONARY TUBERCULOSIS</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MITRAL INSUFFICIENCY</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-8</u> , 19 <u>59</u> , to <u>10-31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-31</u> , 19 <u>59</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above. SIGNATURE, <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Clara R. ...</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		ADDRESS <u>4210 Belair</u>	

DATE NOV 5 '59



11159

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (7) 3✓01-+</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>5623 Wayne Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>REYNOLD</b>		Middle <b>JOHN</b>		Last <b>PENN</b>		4. DATE OF DEATH Month <b>October</b>	
Day <b>27</b>		Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 23, 1899</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John F. Penn</b>				14. MOTHER'S MAIDEN NAME <b>Helen Gerkles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 213-10-2763</b>		Address <b>Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MULTIPLE MYELOMA</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>  <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HEALED PEPTIC ULCER. ARTERIOSCLEROSIS, GENERALIZED.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VA</b>		(County) <b>VA</b>		(State) <b>VA</b>	
21. I certify that I attended the deceased from <b>October 20, 1959</b> , to <b>October 27, 1959</b> , that I last saw the deceased alive on <b>October 27, 1959</b> , and that death occurred at <b>11:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VA H, BALTO. 18, MD. FORT HOWARD DIV.</b>							
ACTUAL SIGNATURE <i>John W. Crawford</i>		DATE SIGNED <b>10/28/59</b>					
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, BALTO. 18, MD. FT. HOWARD, DIVISION 10/28/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kachauskas Funeral Home, 637 Washington Blvd. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

11136

Reg. Dist. No.

11160

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River 20 Md</u>	
c. LENGTH OF STAY IN 1b <u>2 month</u>		d. STREET ADDRESS <u>Seneca Gardens Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seneca Gardens Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HILD A. PORSCHE</u>		4. DATE OF DEATH <u>October 7 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. H. H. H. H.</u>		14. MOTHER'S MAIDEN NAME <u>Miss M. H. H. H.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Henrietta Flanagan Seneca Gardens</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Insanitation;</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>repeated cerebral vascular accidents</u> DUE TO (c) <u>arteriosclerosis generalized</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 17 1959</u> to <u>October 6 1959</u> that I last saw the deceased alive on <u>October 6 1959</u> and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leopoldo Gross</u> M.D.		ADDRESS (Street, city or town, state) <u>201 Ballard Rd</u> DATE SIGNED <u>Oct 8/59</u>	
PHYSICIAN'S NAME (Type) <u>Leopoldo Gross M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 10 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FARMWOOD</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES F. EVANS, JR.</u> ADDRESS <u>8802 HARTFORD RD MD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>William B. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11161

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berryman Lane Sufferland</u>		d. STREET ADDRESS <u>Berryman Lane Sufferland</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Susan Evelyn Porter</u>		4. DATE OF DEATH Month Day Year <u>October 16 1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Libertytown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Smeadner</u>		14. MOTHER'S MAIDEN NAME <u>Laura Keeney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal hemorrhage</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of colon</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1958</u> to <u>October 16, 1959</u> , that I last saw the deceased alive on <u>October 14, 1959</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles M. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Reisterstown, Maryland October 16, 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gruid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '59</u>	
ADDRESS <u>8728 Hartig Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8, Ma.</b>	
c. LENGTH OF STAY IN 1b <b>6 mo.</b>		d. STREET ADDRESS <b>113 Sherwood Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Robbs Nursing Home</b>			
3. NAME OF DECEASED (Type or print) <b>Frances Walker Powell</b>		4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1878</b>
9. AGE (in years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cutler B. Walker</b>		14. MOTHER'S MAIDEN NAME <b>Carey Proctor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Norman S. Powell</b>		Address <b>Pikesville 8, Md. 113 Sherwood Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b>			
450.0 DUE TO (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture femur, right</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Unknown-patient too senile to describe injury.</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>?</b> o. m. <b>Sep. 21 1959</b> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Robb Nursing Home, Pikesville, Balto., Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Oct. 21, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville 8, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 26 59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Wm. S. H. H. H.</b>	

THE MEDICAL EXAMINER: This certificate should be filled within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

11163

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Professional House</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3800 Mohawk Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Aaron</u> Middle <u>Alex</u> Last <u>Radel</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 26, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>1</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial</u>	11. BIRTHPLACE (State or foreign country) <u>Argentina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Morris Radel</u>	
14. MOTHER'S MAIDEN NAME <u>Esther ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		INFORMANT Address <u>Julia Radel - 3800 Mohawk Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>14 mths.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 29, 1959</u> , to <u>Oct 29, 1959</u> , that I last saw the deceased alive on <u>Oct 29, 1959</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Whitehouse</u> M.D.		ADDRESS (Street, city or town, state) <u>2933 N. Charles St</u> DATE SIGNED <u>10/31/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>Oct 31, 59</u>	<u>Cedar Park</u>	<u>Westwood, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Lenson</u> <u>124-26 W. North Ave</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>NOV 3 '59</u>	<u>Carlton S. Kinn</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

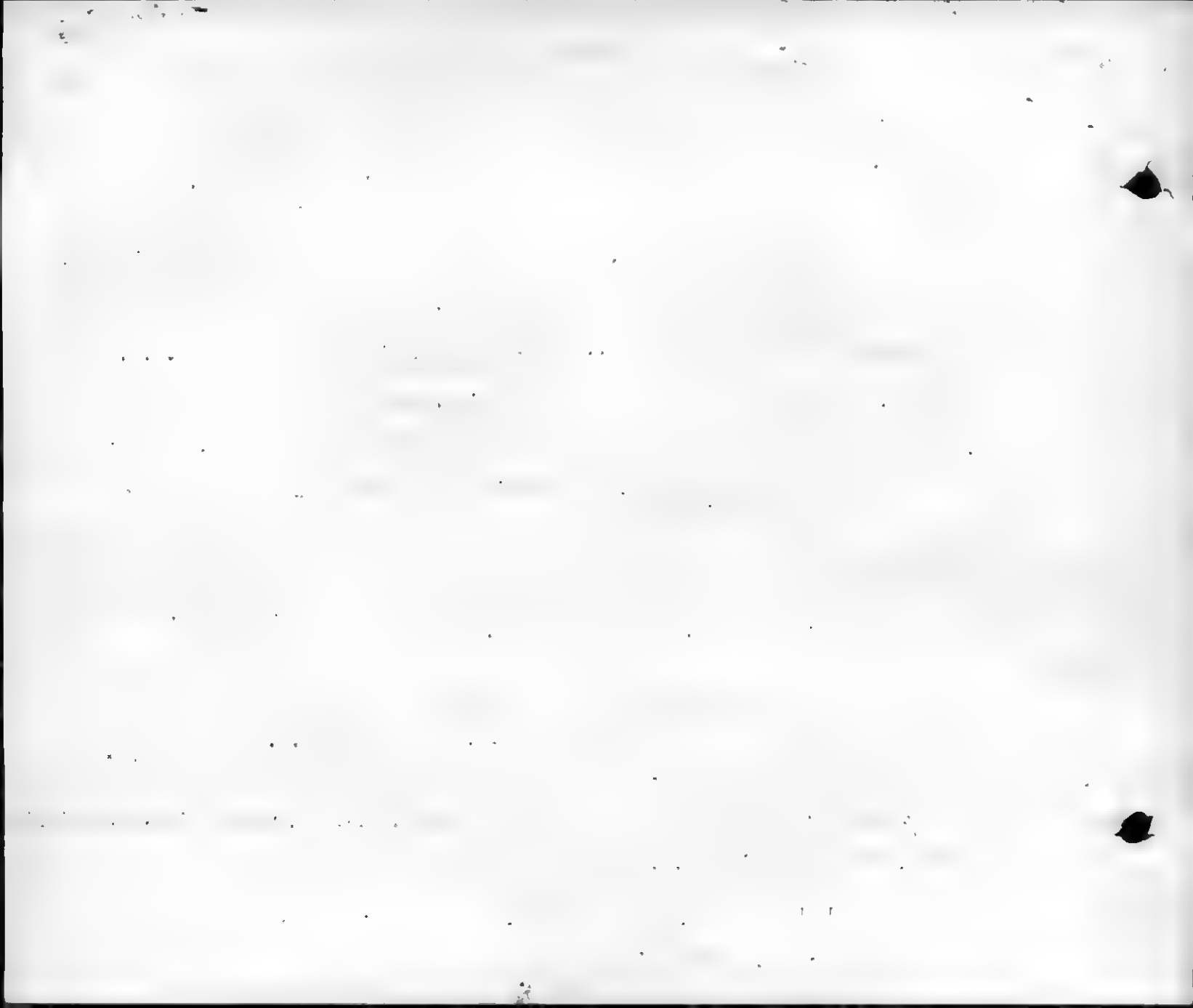
Reg. Dist. No.

11164

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>6-1/2 HRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE (29)</b>	
		f. STREET ADDRESS <b>Oaklee Village, Apt. 33</b>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HUGH</b> Middle <b>S.</b> Last <b>REID</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 10, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Yard, U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>NORFOLK, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW W. REID</b>		14. MOTHER'S MAIDEN NAME <b>IDA E. COOK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES Sp. Am. War</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized.</b> (c) <b>Old myocardial infarction. Pulmonary edema. Marked Arteriosclerosis.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized.</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 29, 1959</b> to <b>October 29, 1959</b> and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD, FT. HOWARD DIVISION</b> DATE SIGNED <b>10/30/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, BALTO. 18, MD, FT. HOWARD DIVISION</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Hubbard Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Orliss L. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11165

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bellona Avenue West of Charles St.,</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> d. STREET ADDRESS <b>Bellona Ave, West of Charles</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Margaret</b> Middle <b>C.</b> Last <b>Reynolds</b>		<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>29</b> Year <b>1959</b>									
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 4, 1881</b> <b>9. AGE</b> (In years last birthday) <b>78</b> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Private home</b>									
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Harford Co, Md</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>Thomas Gordon</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Bradley</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>  <b>17. INFORMANT</b> <b>Cloretta Carnaggio, 2858 W. North Avenue</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> <b>442x</b> DUE TO (b) <b>Hypertensive Cordis Pulvis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REPOSSIT</b> (Specify) <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>11-2-59</b>									
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore Maryland</b>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b>									
<b>William Cook, Inc., 1217 St. Paul Street</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>10/29/59</b>									

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

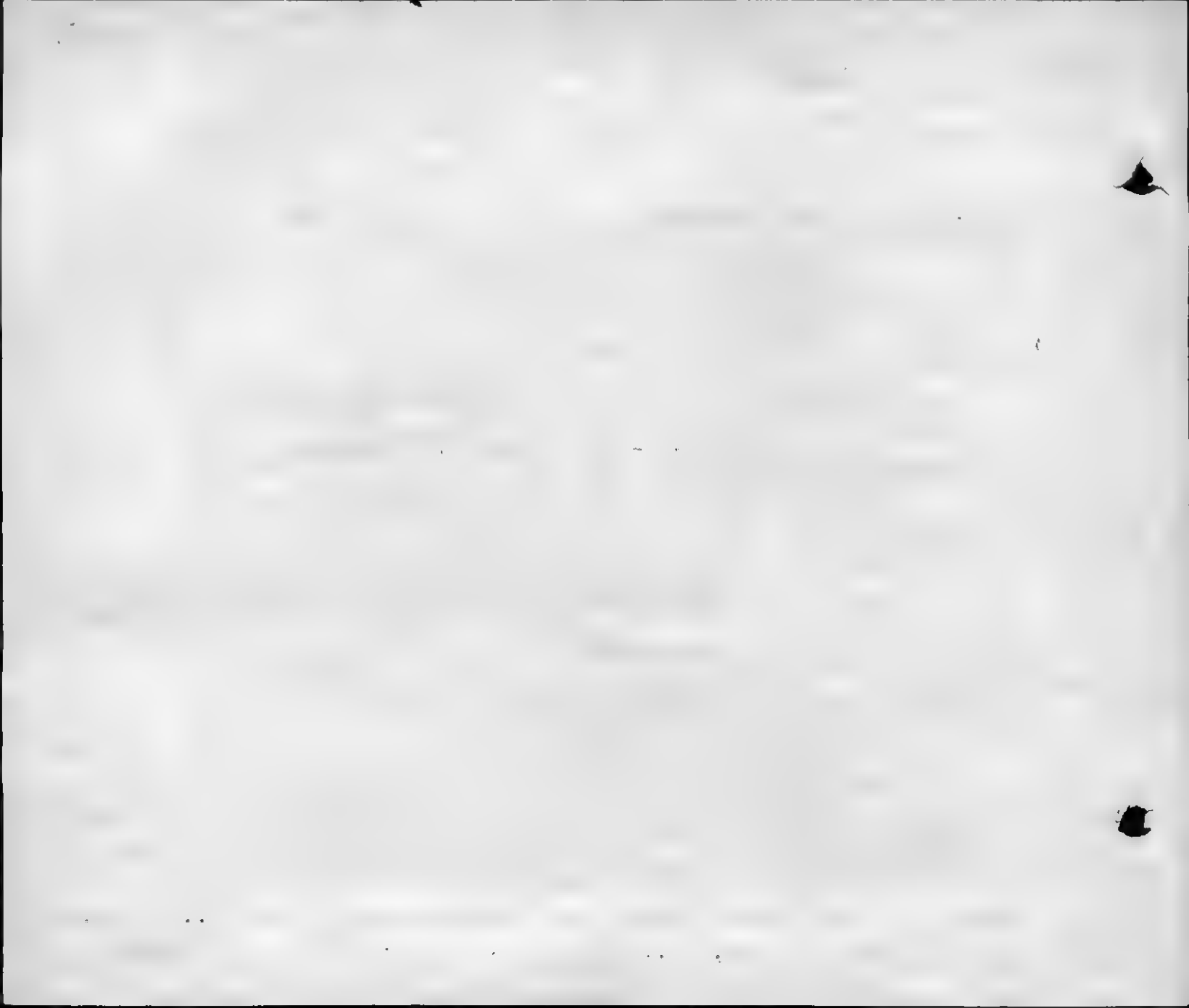




TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abington</b> d. STREET ADDRESS <b>(Box 108)</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 7 just below Pfeiffer Road</b>											
3. NAME OF DECEASED (Type or print) <b>FRANK</b>				4. DATE OF DEATH <b>10 7 1959</b>				5. SEX <b>Male</b>			
6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>5/13/1892</b>			
9. AGE (In years last birthday) <b>67</b> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				11. BIRTHPLACE (State or foreign country) <b>Italy</b>			
10b. KIND OF BUSINESS OR INDUSTRY <b>Selfemployed</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Angelo Ricci</b>			
14. MOTHER'S MAIDEN NAME <b>Anunziata Iacauacci</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-12-9840</b>			
17. INFORMANT <b>Flora C. Ricci</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary arteriosclerosis with old scarring of left ventricular myocardium</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>420.1</b> DUE TO (c) <b>420.1</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10/10/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>			
22d. LOCATION (City, town, or country) <b>Baltimore Co., Maryland</b>				23. FUNERAL DIRECTOR ADDRESS <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur J. ...</b>				25. DATE SIGNED <b>10/8/59</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

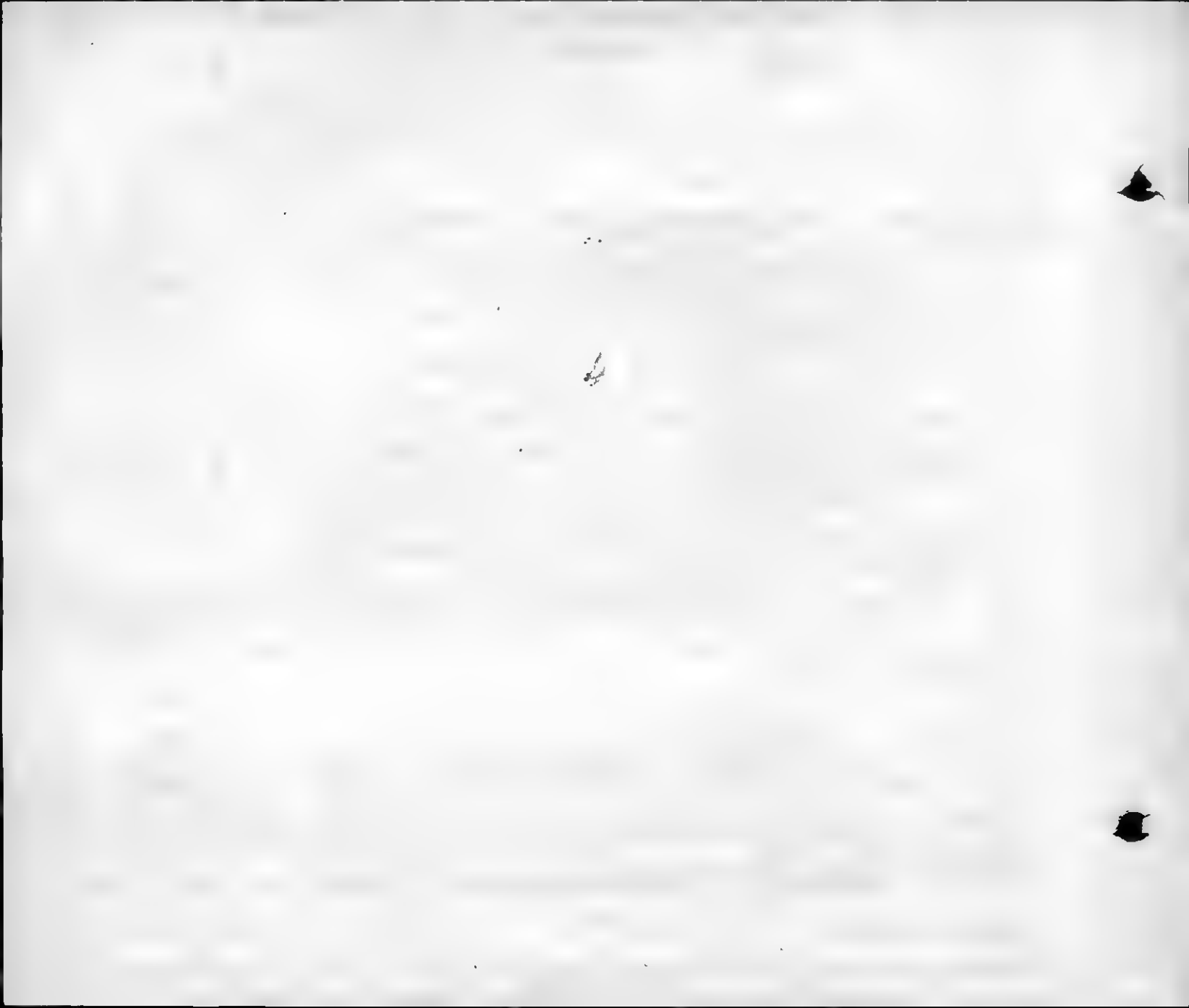
Item 13-1116251 11-4-59 et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

11143

Reg. Dist. No.

11162

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armocost Nursing Home</b>				d. STREET ADDRESS <b>5608 Greenhill Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>BESSIE MAY RICHARDSON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1878</b>	9. AGE (In years last birthday) <b>80</b> yrs	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Schwartz</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Thelma Pool</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> DUE TO <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO <b>Arteriosclerosis</b> (c) <b>Coronary atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>40 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/10, 1959</b> to <b>Oct 26, 1959</b> , that I last saw the deceased alive on <b>Oct 25, 1959</b> , and that death occurred at <b>5 PM</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William T. Brownell, M.D.</b>				ADDRESS (Street, city or town, state) <b>2201 York Rd.</b>		DATE SIGNED <b>10/28/59</b>	
PHYSICIAN'S NAME (Type) <b>William T. Brownell, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/29/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armocost</b>				ADDRESS <b>4600 Liberty Heights Ave.</b>		24a. REC'D BY REGISTRAR <b>OCT 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. S. L. Kline</b>			



11168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - RoseDAle</b>		c. LENGTH OF STAY IN lb <b>13 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1212 Hilldale Ave</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural - RoseDAle</b>	
3. NAME OF DECEASED (Type or print) <b>SALVATORE (Samuel) Rizzo</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1918</b>
9. AGE (In years last birthday) yrs. <b>41</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rheem Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Bridgeton, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>SANTO Rizzo</b>		14. MOTHER'S MAIDEN NAME <b>Maria SAYA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO <b>142-09-6587</b>	
17. INFORMANT <b>Maria C. Rizzo</b>		Address <b>1212 Hilldale Ave. - 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <b>Adenocarcinoma of stomach</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>Approx 1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>MAR</b> 19 <b>58</b> , to <b>Oct 8</b> 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 8</b> 19 <b>59</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Theodore E. Evans</b> M.D. <b>9660 Belair Rd.</b>		<b>Oct 8, 1959</b>	
PHYSICIAN'S NAME (Type) <b>THEODORE E. EVANS. BALTO. C. MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Oct. 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE National Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Covich</b>		ADDRESS <b>1211 Chesaco Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Evans</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 X  
FOR STATE  
HEALTH DEPT.

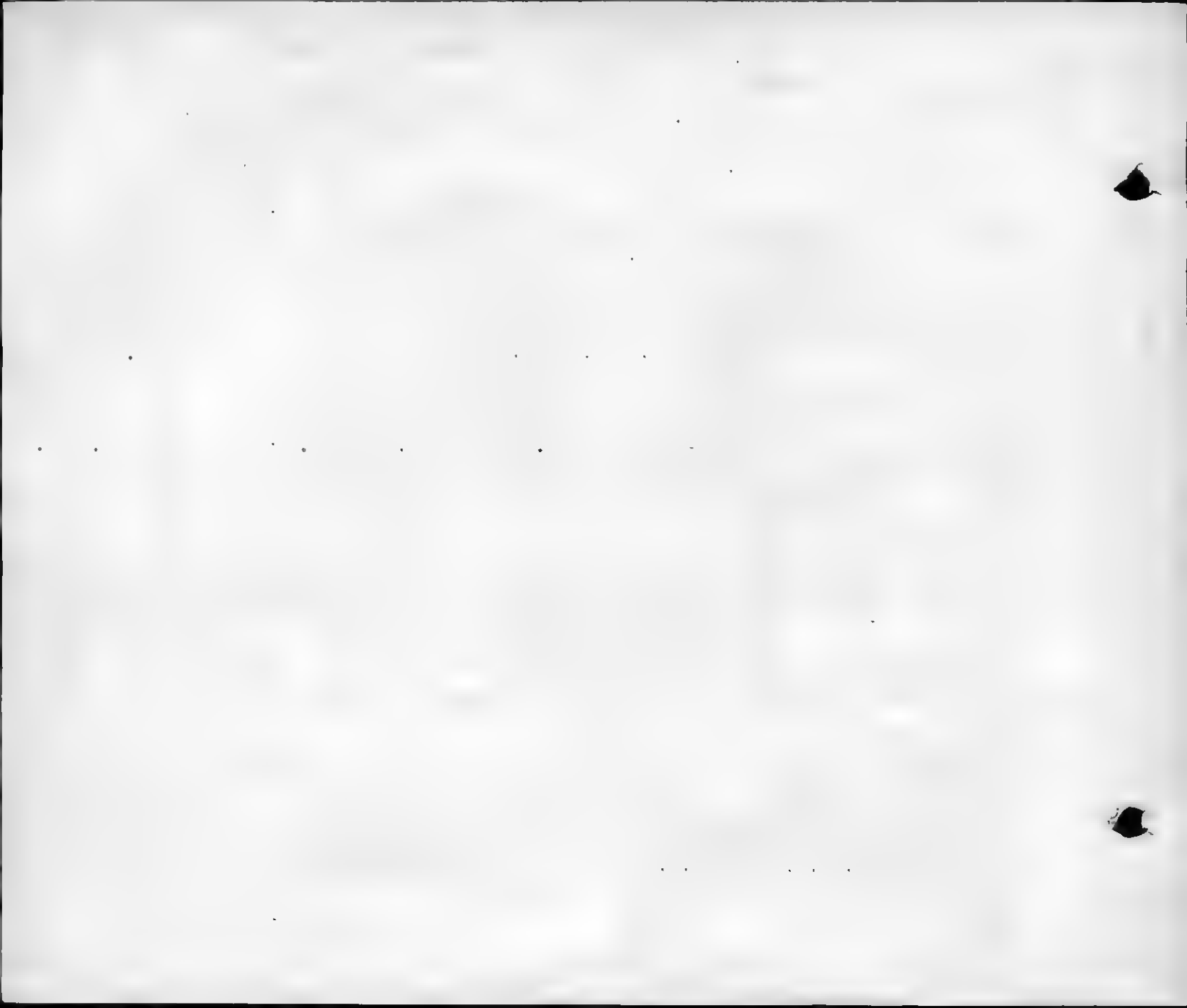
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> <u>County</u> <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point 19, Md.</u>		c. LENGTH OF STAY IN 1b <u>19</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Hospital</u>		d. STREET ADDRESS <u>Sparrows Point 19, Md.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence F. Robertson</u>		4. DATE OF DEATH Month Day Year <u>October 2 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-95</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Middleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>216-10-4762</u>	
17. INFORMANT <u>Wm. Robertson</u>		Address <u>500 No. Bouldin Balto., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>1 0 1 E</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>E</u>	20f. (City or town) (County) (State) <u>Baltimore</u> <u>Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M B Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-2-59</u>	
EXAMINER'S NAME (Type) <u>Dr. M. B. Davis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

11146

11170

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>M.</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William N. Mays</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 36 9528</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-20-</u> , 19 <u>59</u> , to <u>10-9-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-9-</u> , 19 <u>59</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Robinson</u>		ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>10-10-59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD ROBINSON</u>		<u>NEW FREEDOM, PA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 12, 1959</u>	<u>Mt. Zion Cemetery</u>	<u>Freeland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		24a. REC'D BY REGISTRAR <u>Oct 13 59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur B. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be regarded as the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

these registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

32

11171

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>11171</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOUNT AIRY</b> d. STREET ADDRESS <b>ROUTE 3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB SULLIVAN ROGERS</b>		4. DATE OF DEATH Month Day Year <b>10 5 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-'85</b>
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	
11. BIRTHPLACE (State or foreign country) <b>TENN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JERRY ROGERS</b>		14. MOTHER'S MAIDEN NAME <b>RUTH STANTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FAR ADVANCED PULMONARY TUBERCULOSIS</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-22-1959</b> to <b>10-5-1959</b> , that I last saw the deceased alive on <b>10-4-1959</b> , and that death occurred at <b>7:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		<b>Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Clagetsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Moleworth</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR <b>ACT 7-59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles J. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11172

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>118 OAK DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MINERVA TRIPLETT ROLLEY</b>		4. DATE OF DEATH Month Day Year <b>OCT. 2 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 22, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>ARTHUR W. TRIPLETT</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLEN GASKINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ronelle T. Rolley - 118 Oak Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic vascular dis.</b> DUE TO (c) <b>Arteriosclerotic vascular dis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1959</b> to <b>Oct. 1959</b> that I last saw the deceased alive on <b>Oct. 2 1959</b> and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Christian S. Mass, M.D. 11 E. Chase + 908 Fred. 10/2/59</b>			
ACTUAL SIGNATURE <b>Christian S. Mass</b>		PHYSICIAN'S NAME (Type) <b>Christian S. Mass</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>10-5-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fairfax Funeral Home - Catonsville, Ind.</b>		ADDRESS <b>118 Oak Drive</b>	
24a. REC'D BY REGISTRAR <b>DATE 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Christine S. Mass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11173

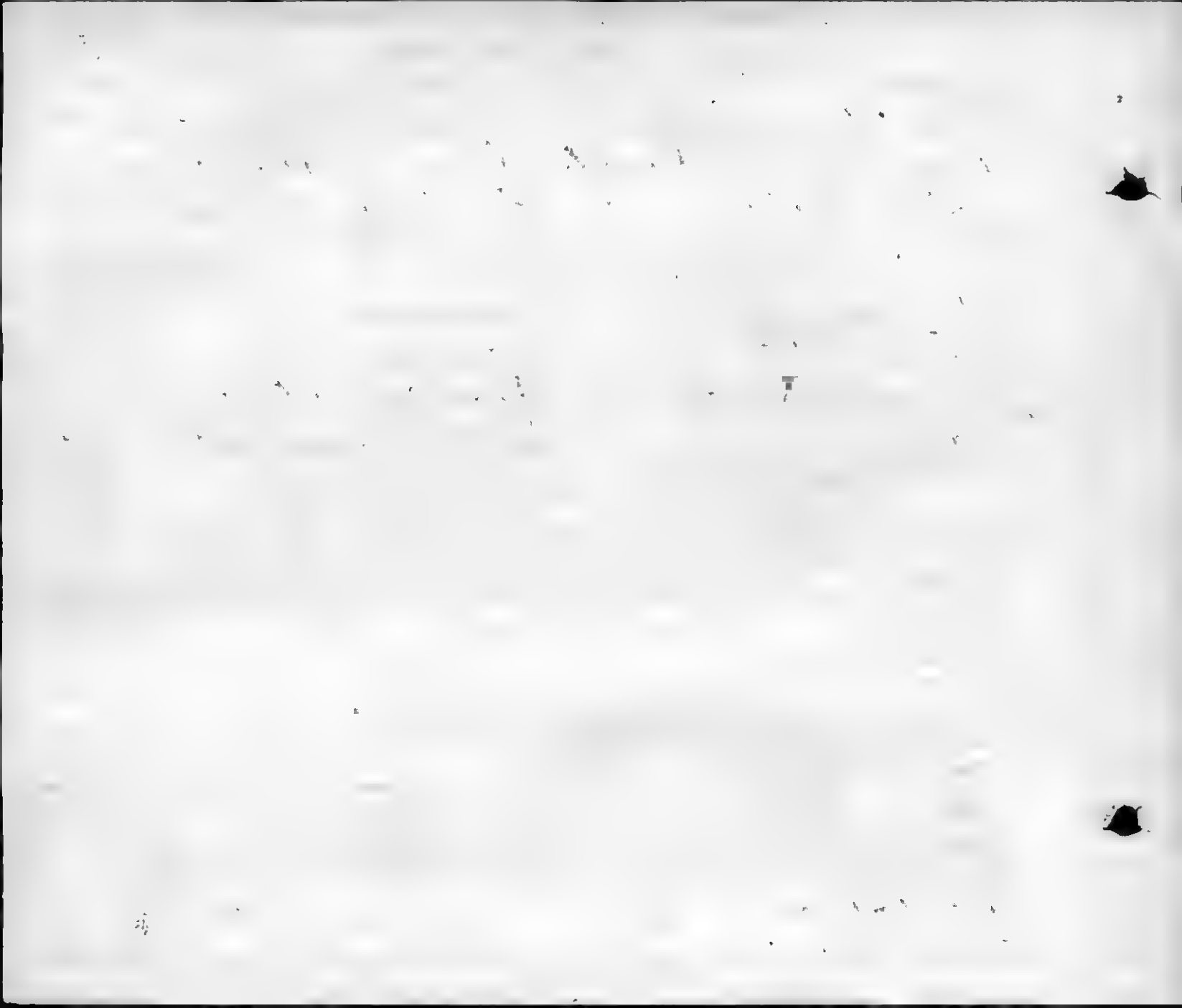
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEHURST</b>				c. LENGTH OF STAY IN 1b <b>1 WEEK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2314 Bwth AVE.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TURNERS STATION</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Wm. Las. Rollins Jr.</b>				4. DATE OF DEATH Month <b>10</b> - Day <b>18</b> Year <b>1959</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-20-1907</b>	
				9. AGE (In years last birthday) <b>51</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker Shipyard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. Md.</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Wm. Las. Rollins Sr.</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH DUCKETT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>ALICE ROLLINS</b>				Address <b>105 WALNUT AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>							
4. DUE TO <b>Influenza Virus</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>about 10 days</b>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 18, 1959</b> to <b>October 18, 1959</b> , that I last saw the deceased alive on <b>October 18, 1959</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <b>107 N. Main St. Baltimore Md.</b>							
DATE SIGNED <b>10/20/59</b>							
ACTUAL SIGNATURE <b>John Thomas</b>							
PHYSICIAN'S NAME (Type) <b>John Thomas</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>10-21-59</b>		<b>Mt. Calvary Cem.</b>		<b>A.A. County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Milton E. Elickson</b>				24a. REC'D BY REGISTRAR <b>Caroline E. Elickson</b>			
ADDRESS <b>1129 N.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Elickson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11150

11174

1. PLACE OF DEATH a. COUNTY <b>Rosewood State Training School</b> <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>				c. LENGTH OF STAY IN 1b <b>3 yrs 4 mo</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Gerard</b> Last <b>Russo</b>				4. DATE OF DEATH Month <b>10</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/56</b>		9. AGE (In years last birthday) <b>3 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Frank Biagio Russo</b>				14. MOTHER'S MAIDEN NAME <b>Marguerite Jacquelyn Gray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----		INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to aspiration of food</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hydrocephalus, severe (35in)</b> DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH <b>since birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>Oct 3, 1959</b> , that I last saw the deceased alive on <b>Oct 3, 1959</b> , and that death occurred at <b>7:18 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Olive Reid Harris</b>				ADDRESS (Street, city or town, state) <b>Rosewood School</b> DATE SIGNED <b>10/3/59</b>			
PHYSICIAN'S NAME (Type) <b>Olive Reid Harris</b>				<b>Owings Mills, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson Inc. 1050 York Rd., Towson, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11151

Reg. Dist. No.

11175

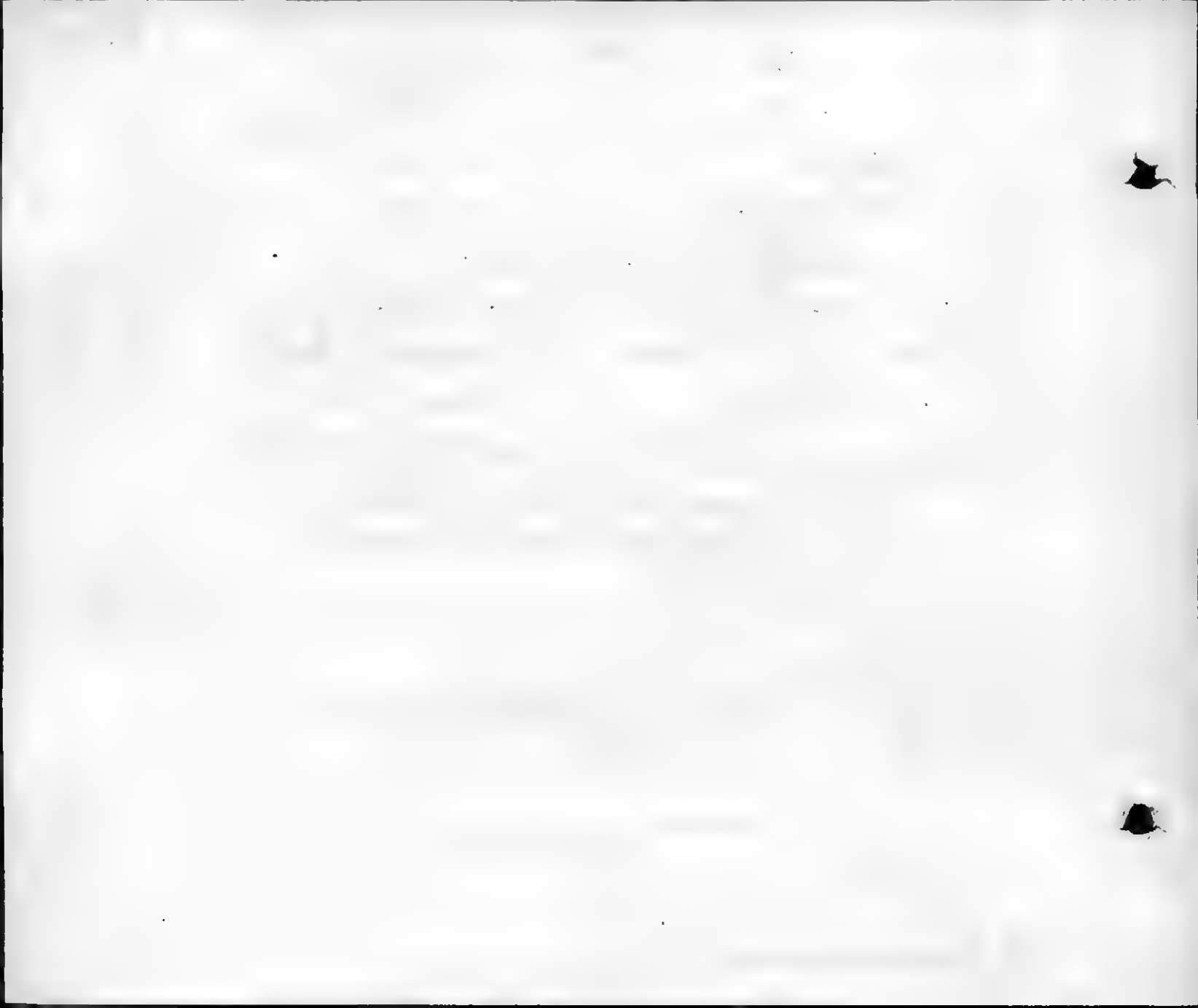
## CERTIFICATE OF DEATH

Items 8 &amp; 9 fill in 11/3/59 jml

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6502 Kriel Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>DUNNE</b> Last <b>SANDS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1894</b>
9. AGE (In years last birthday) <b>65/66</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>13</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Montgomery, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>R. Lawrence Dunne</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-4743</b>	
17. ADDRESS <b>Margaret Alice Sands-6502 Kriel Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crownary Occlusion</b> 420.1 DUE TO <b>Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>59</b> , to <b>10/13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/13</b> , 19 <b>59</b> , and that death occurred at <b>12:20</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eliot W. Johnson</b>		ADDRESS (Street, city or town, state) <b>3432 Frederick Ave. Baltimore 29 Md</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>10/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/19/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Margaret's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery, Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REC'D BY REGISTRAR <b>OCT 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11152

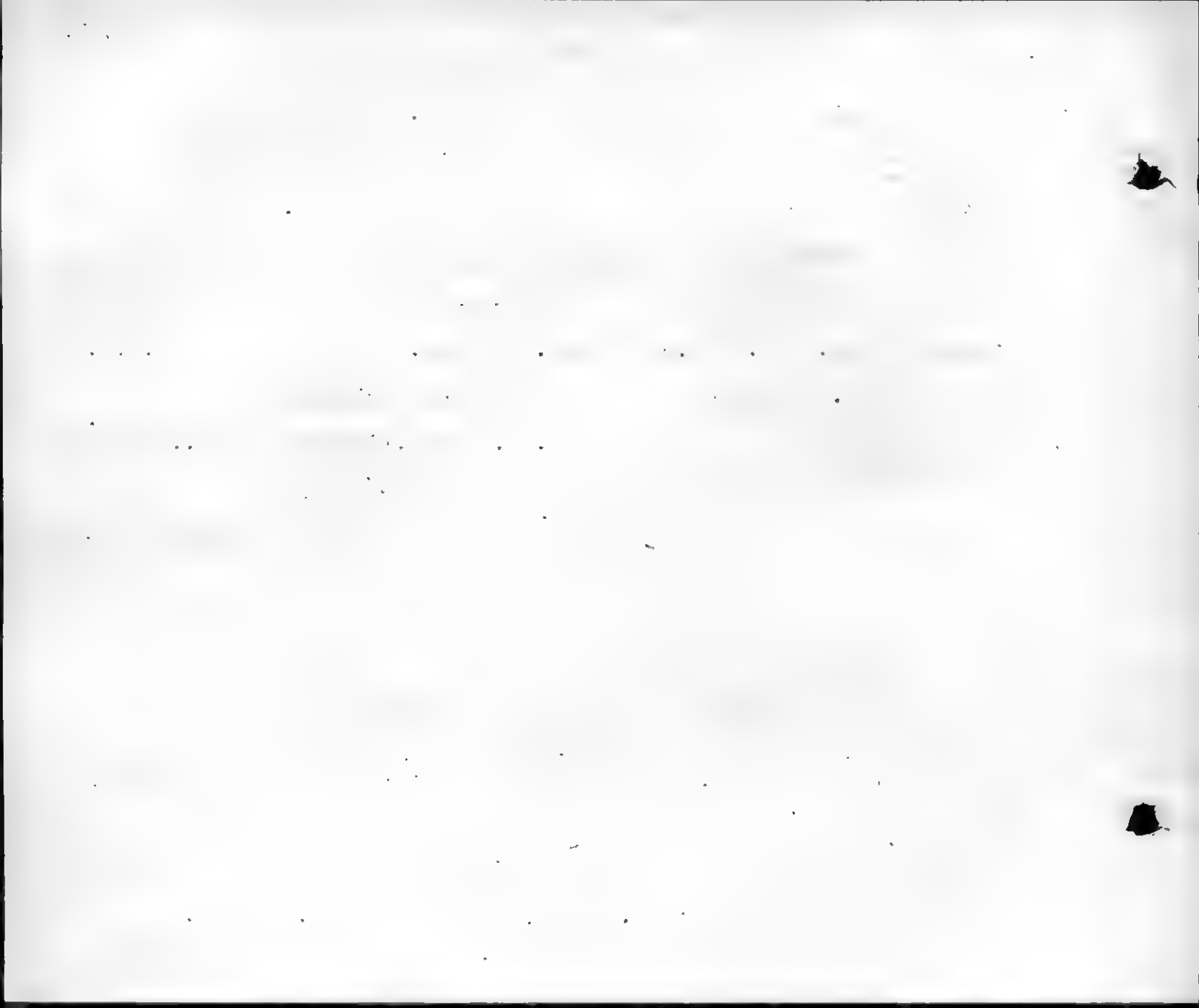
11176

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4,</b>				c. LENGTH OF STAY IN TB <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Oswald Martin Saterlie</b>				4. DATE OF DEATH Month Day Year <b>10-6 1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-1894</b>		9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector Int. Rev.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govern.</b>		11. BIRTHPLACE (State or foreign country) <b>Minn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry M. Saterlie</b>				14. MOTHER'S MAIDEN NAME <b>Anna Marie Tew</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO <b>???</b>			
17. INFORMANT <b>W. M. Kurtz, 1710 Kurtz Ave., Lutherville</b>				Address <b>Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Metastases</b> 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Pancreas</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>18 months</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct 4</b> 19 <b>59</b> to <b>Oct 6</b> 19 <b>59</b> that I last saw the deceased alive on <b>Oct 5</b> 19 <b>59</b> and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>				ADDRESS (Street, city or town, state) <b>7501 2nd Rd</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>				DATE SIGNED <b>10/8/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 28, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinn</b>	

1  
Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11172

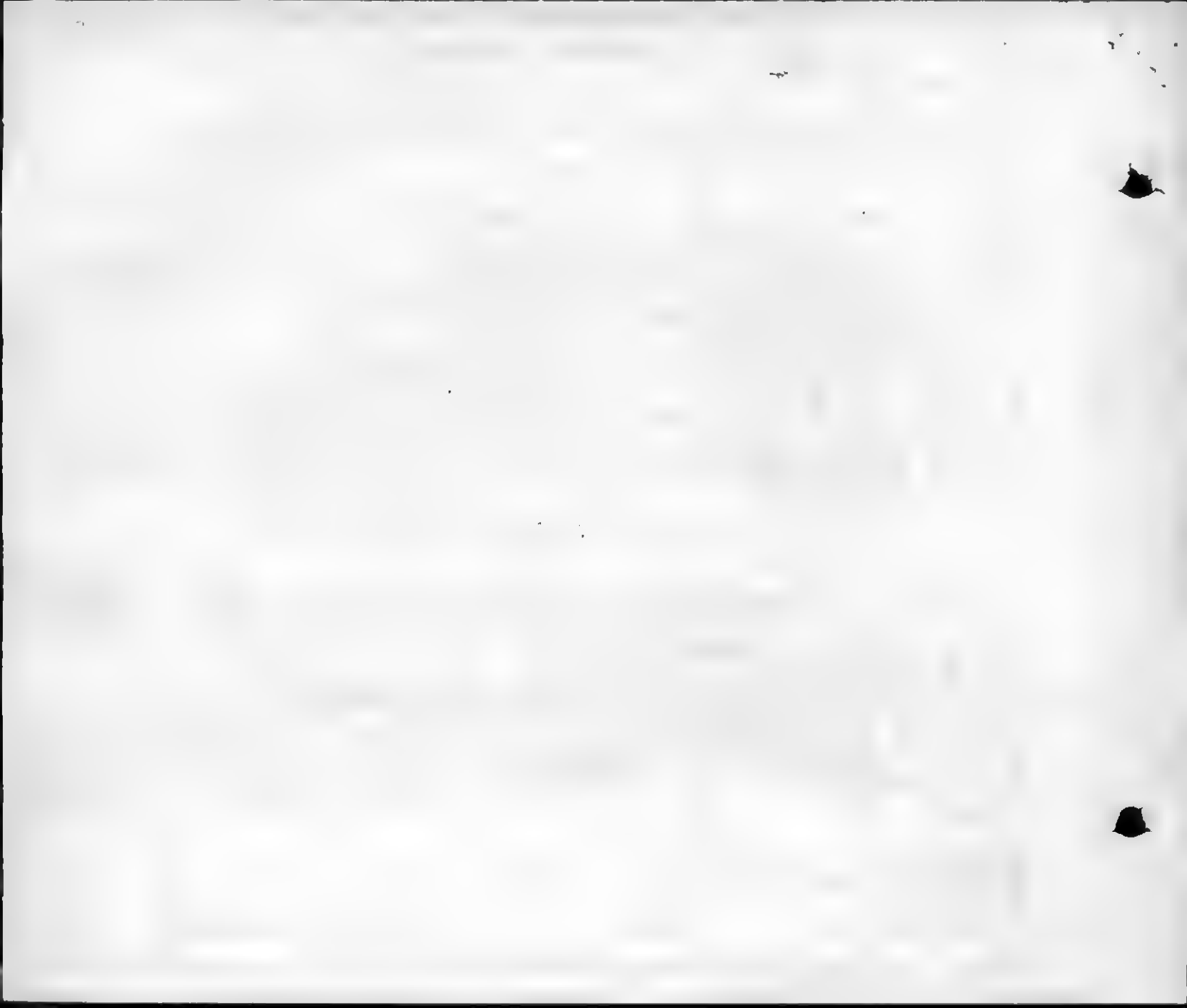
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>964 Radcliff Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>964 Radcliff Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alicia C Scally</u>		4. DATE OF DEATH <u>Oct 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 12, 1924</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT J BARR</u>		14. MOTHER'S MAIDEN NAME <u>ANNA M. Mc NALLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>EDWARD M. Scally 964 Radcliff Rd</u>	
17. INFORMANT <u>EDWARD M. Scally 964 Radcliff Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Carcinoma left breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 24<sup>th</sup> 1958</u> , to <u>SEP 7<sup>th</sup> 1959</u> , that I last saw the deceased alive on <u>SEP 5<sup>th</sup> 1959</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. K. Quinn</u> M.D. <u>1927 YORK RD, TIMONIU</u>		DATE SIGNED <u>10/8/59</u>	
PHYSICIAN'S NAME (Type) <u>M. K. QUINN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S LEM</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS &amp; SON</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>William B. Knead</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11154

Reg. Dist. No.

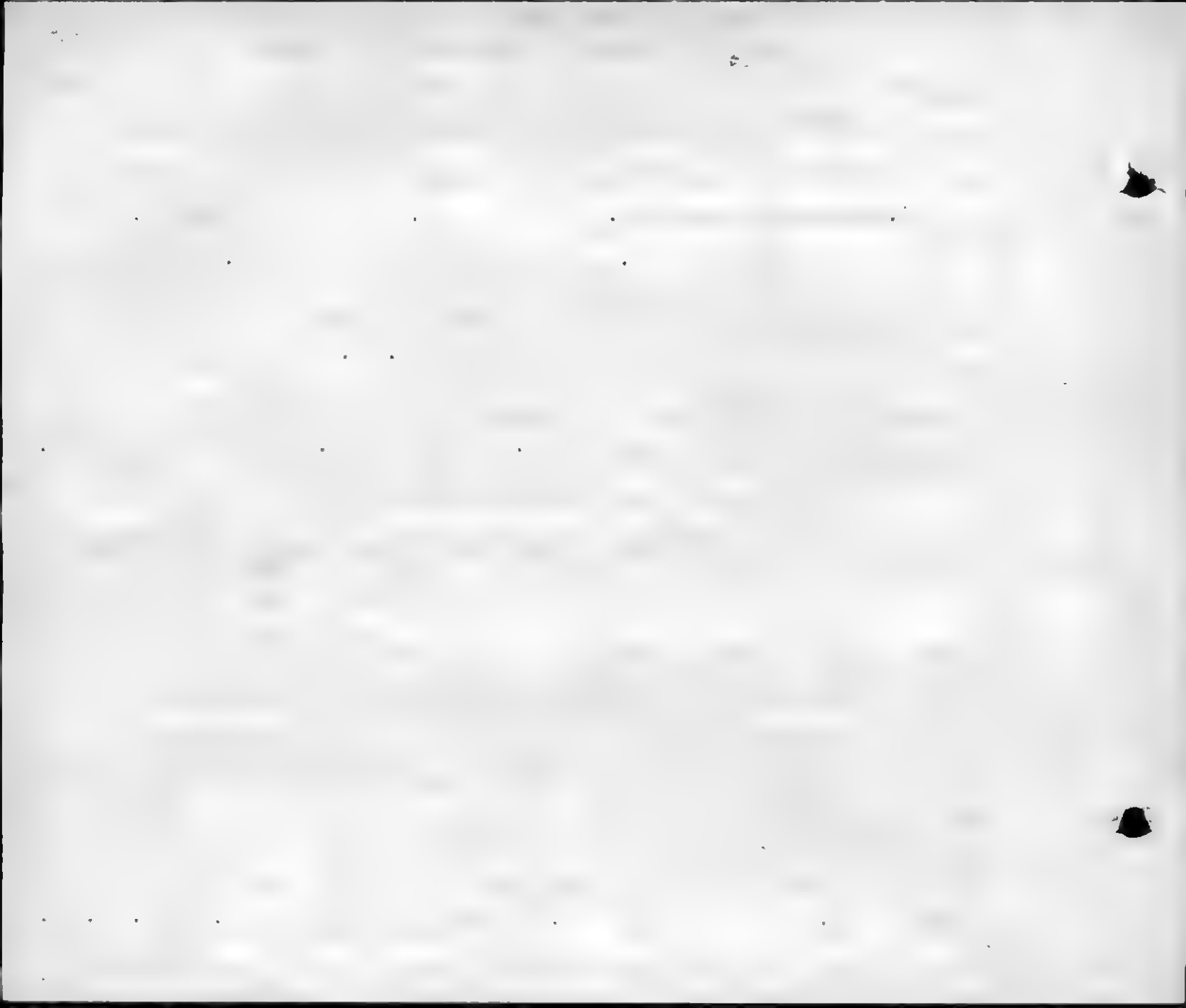
11178

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 16 Box 249 Ebenezer Rd.</u>		e. STREET ADDRESS <u>Rt. 16 Box 249 Ebenezer Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William P. Schaadt</u>		4. DATE OF DEATH <u>Oct. 1, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phillip Schaadt</u>		14. MOTHER'S MAIDEN NAME <u>Christina Volz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary Unkart</u>		Address <u>Rt. 16 Box 249 Ebenezer Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA of Prostate</u> (c) <u>14</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>54</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CA of Prostate</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack E Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK E COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 4, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Golden Ring Rd. Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassak Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Oct 8 '59</u>	
ADDRESS <u>7401 Belair Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Kiana</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11179

CERTIFICATE OF DEATH

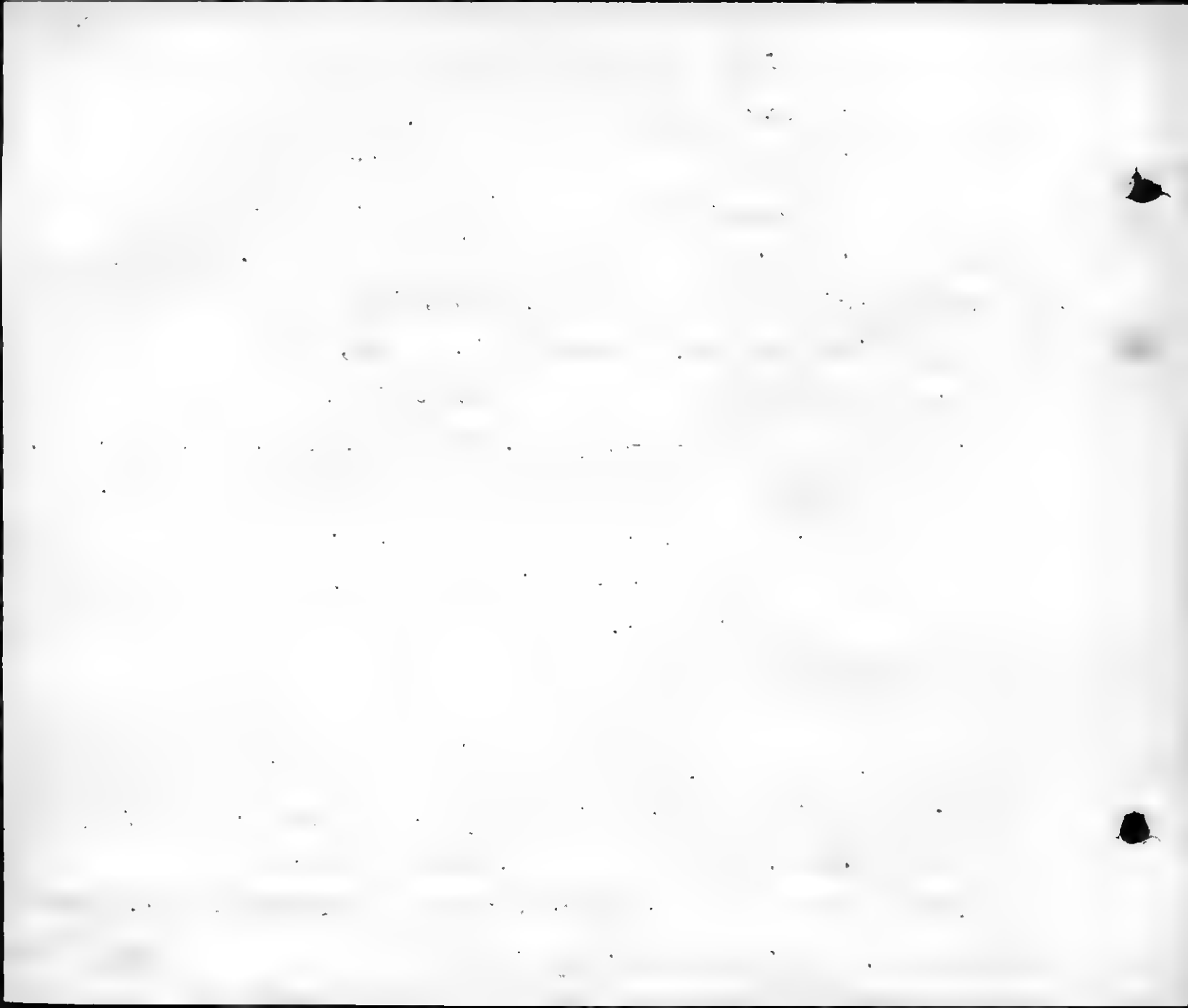
11155

Reg. Dist. No.

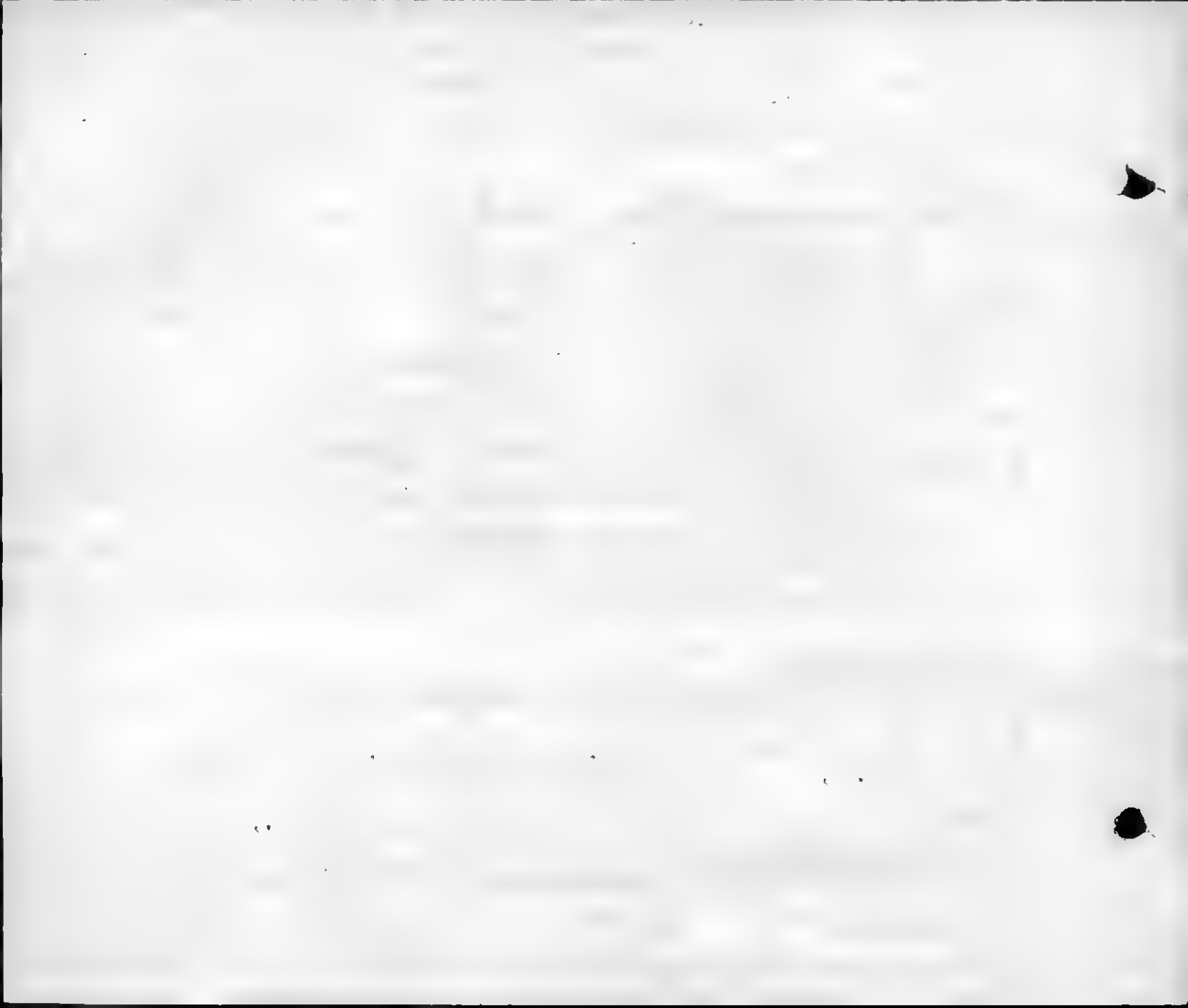
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9005 Harford Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. E. Albert Schimmel</i>		4. DATE OF DEATH <i>October 30th 19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 14th 1895</i>
9. AGE (In years last birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman Bethlehem Steel Company</i>		11. BIRTHPLACE (State or foreign country) <i>Cincinnati, Ohio</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Cornelius Schimmel</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret ?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>Yes</i> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218-03-6199</i>		17. INFORMANT <i>Mrs. Marie Schimmel</i> Address <i>3122 Glendale Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock &amp; Apnea</i> 4 20.1 DUE TO <i>Recurrent Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Recent attacks (10 wks ago) c</i> (b) <i>Recent attacks (10 wks ago) c</i> (c) <i>Atherosclerotic disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> " <i>10 wks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 6 19 59</i> to <i>Oct 30 19 59</i> , that I lost saw the deceased alive on <i>Oct 30 19 59</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Frank T. Kasik, Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>9005 Harford Road #14</i> DATE SIGNED <i>10/30/59</i> PHYSICIAN'S NAME (Type) <i>Frank T. Kasik</i> <i>Baltimore, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/2/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>NOV 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Carlton S. King</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







11181

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

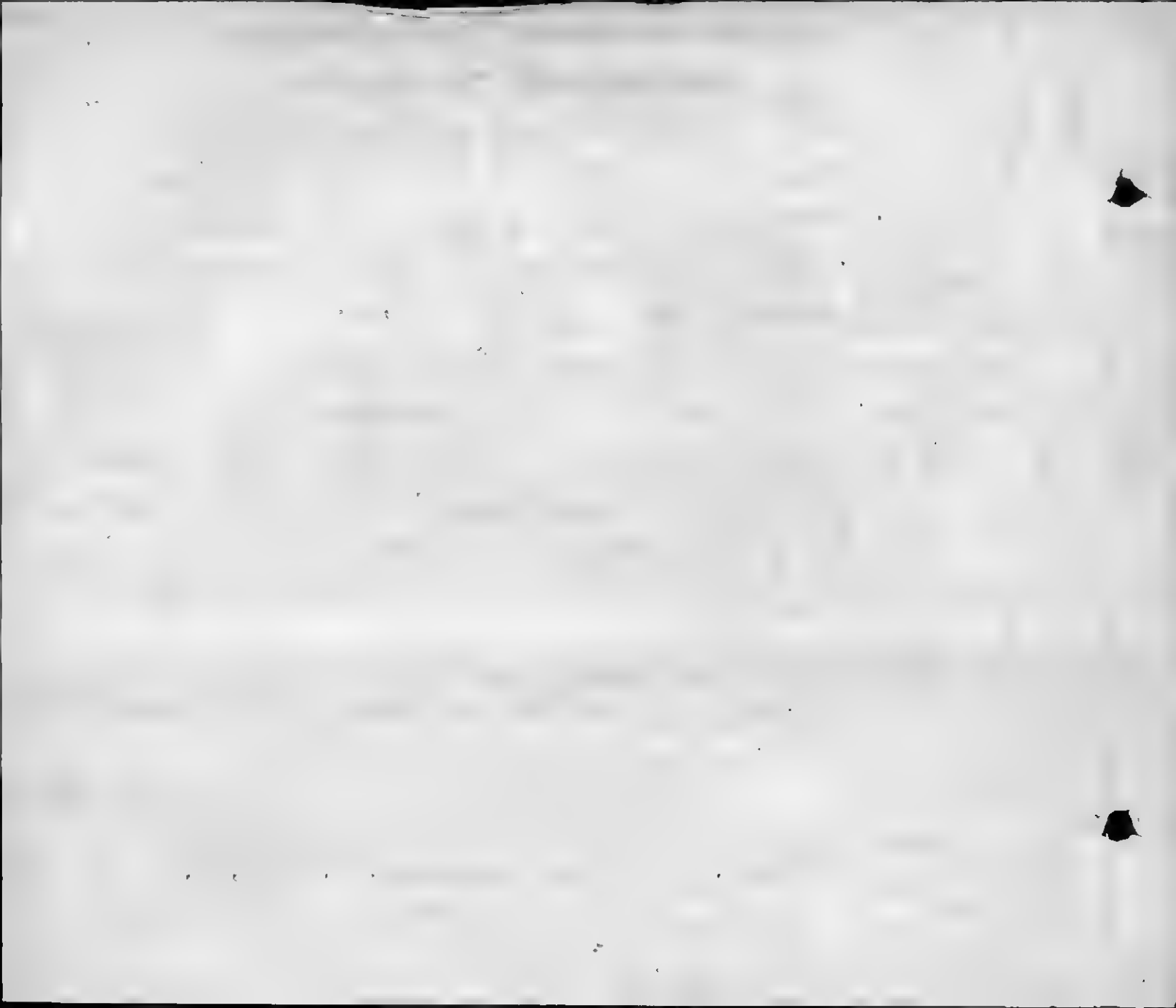
## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto. City</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (In this place) <u>27 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>3201 Woodland Ave #15</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Albert GODFRED Schuele, Sr.</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>10 10 19 59</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>8/10/98</u>	<b>9. AGE last birthday</b> <u>61</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Electrician?</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Albert F. Schuele</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Anbuhler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Far Advanced Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. _____		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>6/18</u> , 19 <u>57</u> , to <u>10/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>59</u> , and that death occurred at <u>12:04 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Wm. Newcomer</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>		<b>DATE SIGNED</b> <u>10/10/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>10/13/59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>11 3 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>C. L. G. Lewis</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. T. Schuele</u>		<b>ADDRESS</b> <u>Balto - 17, Md</u>	





11182

## CERTIFICATE OF DEATH

11158

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

ANDREW SCHULTZ

2. DATE  
OF  
DEATH

October 15, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland **BALTIMORE, Co.**B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

724 Walker Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE Maryland B. COUNTY BALTIMORE

C. CITY OR TOWN (If outside corporate limit, give township)

Baltimore Co.

D. STREET ADDRESS (If rural, give location)

724 Walker Avenue

c. Length of stay in Baltimore

75 Years

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

April 23, 1883

9. AGE (In years  
last birthday)

76

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, or last retired)

Retired Steam Fitter

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Dora

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Marie Eaton 724 Walker Avenue

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING ITINTERVAL BETWEEN  
ONSET AND DEATHIF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21a. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21f. HOW DID INJURY OCCUR

22 I certify that (I) (this hospital) attended the deceased from Jan 1st 1959, that (I) (we) last saw the deceased alive on Oct 15-73 1959, and that death occurred at 11:10 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS ☒24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 19, 1959

Holy Rosary

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler Inc. 1901 Eastern Ave.

THIS IS A PERMANENT RECORD.

PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

Page 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11183

## CERTIFICATE OF DEATH

11159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Rosedale</u>				c. LENGTH OF STAY IN 1b <u>19 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7939 Bridge Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marie Frances Seabreeze</u>				4. DATE OF DEATH <u>Oct 20 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Thomas Kutcher</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Kuzel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>217-05-0282</u>		17. INFORMANT <u>Lawrence Seabreeze</u> Address <u>7939 Bridge Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> DUE TO <u>Phlebitis lower extremities</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>59</u> , to <u>Oct 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 19</u> , 19 <u>59</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.M. Baumgardner M.D.</u>				ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>			
PHYSICIAN'S NAME (Type) <u>G.M. Baumgardner</u>				DATE SIGNED <u>10/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cwach</u> ADDRESS <u>1211 Chesaco Ave.</u>				24a. REC'D BY REGISTRAR <u>OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. S. Thomas</u>	



11184

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baynesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8646 Rock Oak Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Freida (Frieda)</u> Middle <u>A.</u> Last <u>Semerad</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Clara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Jeremiah G. Semerad</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Coronary artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 20, 1959</u> to <u>Oct 10, 1959</u> that I last saw the deceased alive on <u>Sept 20, 1959</u> and that death occurred at <u>9:45 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph F. Li Pira M.D.</u>		ADDRESS (Street, city or town, state) <u>8400 Rock Oak Rd. Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH F. LIPIRA MD.</u>		DATE SIGNED <u>9/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Govan's Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargford Rd.</u>	
24a. REC'D BY REGISTRAR <u>OCT 13 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

11161

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> Not given <u>12X3</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home For Aged</u>				d. STREET ADDRESS <u>12121 Yugwell Drive</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Karolina Sendrowski</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Oct. 29 1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4. 1871</u>			
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>									
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pericardial infarction</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intracranial thrombosis</u> DUE TO (c) <u>Chronic Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension - Chronic Failure</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. Month. Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>June 1958</u> to <u>Oct 1959</u> , that I last saw the deceased alive on <u>Oct 29 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state), <u>1102 E. J. J. Rd.</u>				DATE SIGNED <u>10/30/59</u>					
ACTUAL SIGNATURE <u>Victor F. King</u>				M.D. <u>1102 E. J. J. Rd.</u>					
PHYSICIAN'S NAME (Type) <u>Victor F. King</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 31. 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozazewski</u>				ADDRESS <u>1930 Eastern Ave.</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>					

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11186

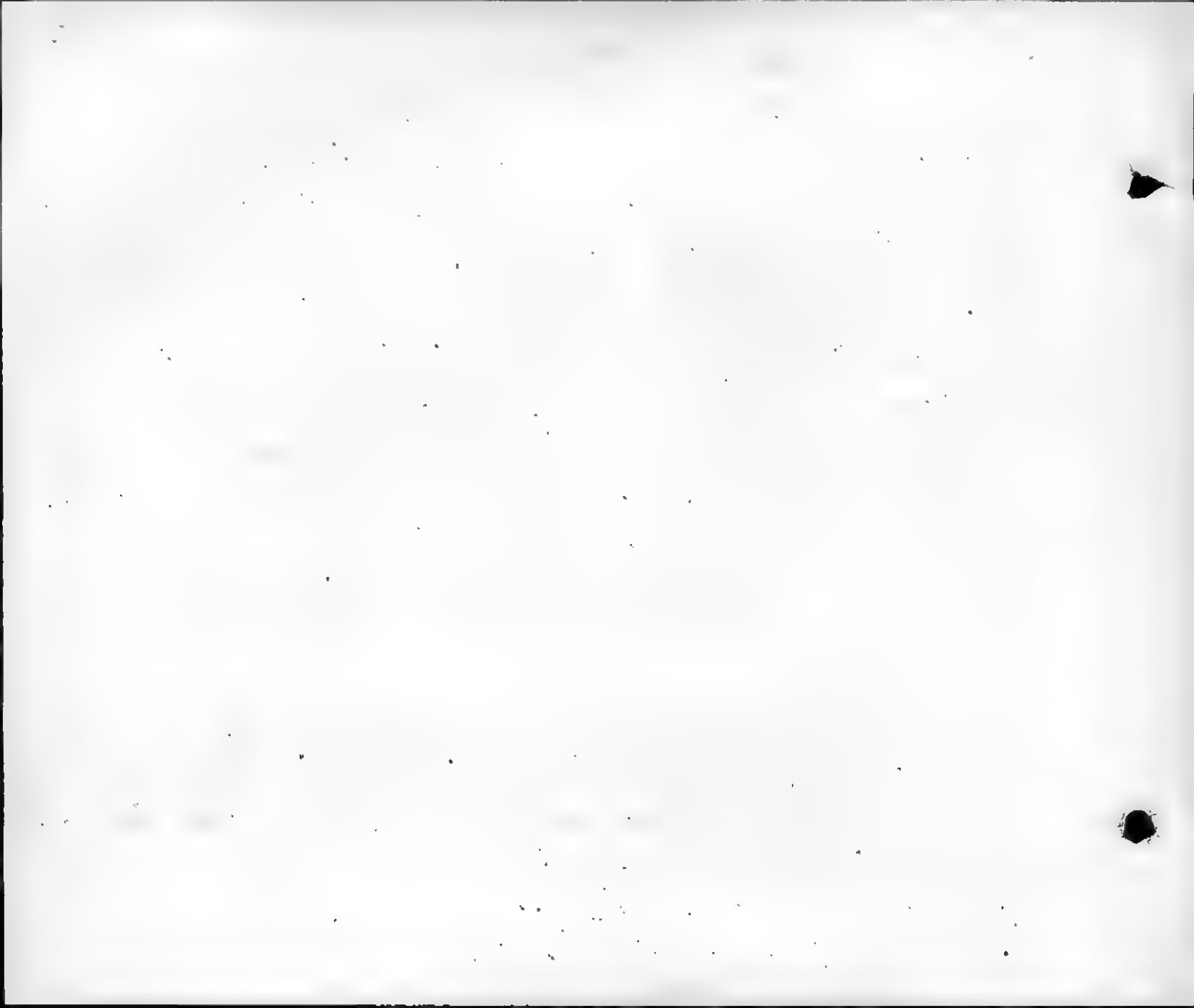
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>East</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 Smith Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE SHAPIRO</u>		4. DATE OF DEATH <u>10-10-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>72</u> yrs.
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Lith</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Isaac Sauber</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ivring Shapiro</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis of coronary arteries</u> DUE TO (c) <u>arteria</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>49</u> to <u>Oct 10</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> . M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin Sauber</u> M.D.		ADDRESS (Street, city or town, state) <u>7300 Park Heights Ave</u> DATE SIGNED <u>9/10/59</u>	
PHYSICIAN'S NAME (Type) <u>IRVIN SAUBER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) <u>Balto</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u> ADDRESS <u>2100 Eutaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Clinton &amp; Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

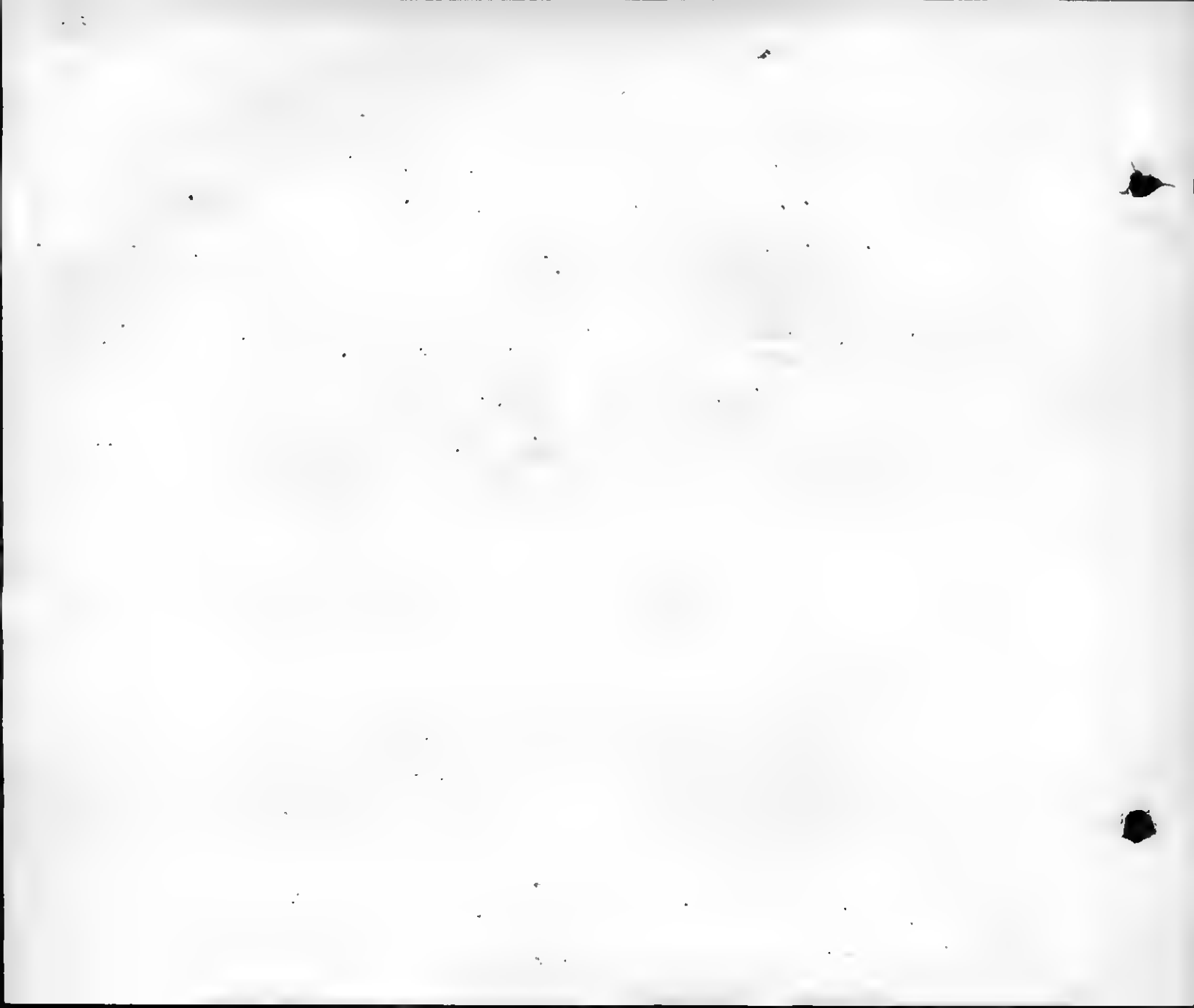


1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		e. STREET ADDRESS <u>2417 Hunt Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>Shapiro</u> Last		4. DATE OF DEATH Month <u>10</u> - Day <u>11</u> - Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday yrs. <u>35</u> )		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Shapiro</u>		14. MOTHER'S MAIDEN NAME <u>Anne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Solomon Schapiro - Same</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Myoc. Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Premier Myoc. Infarction</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10</u> , 1959 to <u>10/11</u> , 1959, that I last saw the deceased alive on <u>10/11</u> , 1959, and that death occurred at <u>9:20</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max J. Miller</u>		ADDRESS (Street, city or town, state) <u>1047 Ingleside Ave</u>	
PHYSICIAN'S NAME (Type) <u>Jack Lewis M.D.</u>		DATE SIGNED <u>10/12/59</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Roth T. Philon</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis M.D.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>2100 Cutaw Place</u>		DATE <u>OCT 14 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove address papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

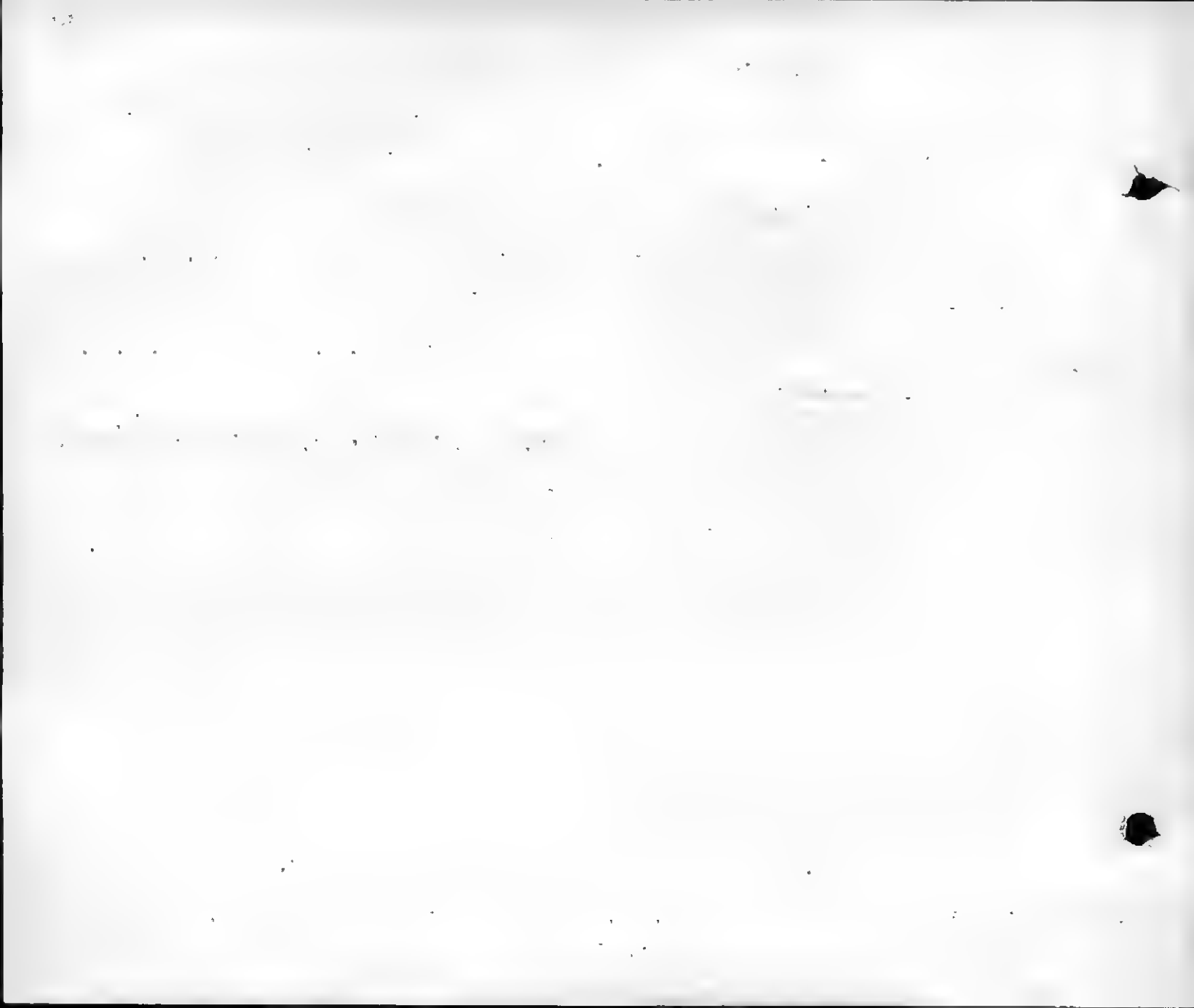
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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>23 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>213 B. Maiden Choice Lane</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>GANNON</b> Last <b>SHAUGHNESS</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1887</b>
9. AGE (In years lost birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Albany, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Gannon</b>		14. MOTHER'S MAIDEN NAME <b>Della Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. J. J. Luecking Jr.</b>		Address <b>Catonsville 28, Md.</b> <b>102 Fairfield Drive,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio sclerosis cardiovascular d.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1957</b> to <b>25 October 1959</b> that I last saw the deceased alive on <b>25 October 1959</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1011 Frederick Rd. #28</b> DATE SIGNED <b>10/26/59</b> ACTUAL SIGNATURE <b>James E. Rowe</b> M.D. PHYSICIAN'S NAME (Type) <b>James E. Rowe</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal for Burial</b> 22b. DATE THEREOF <b>10/27/1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Agnes Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Albany, N. Y.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Aston Jones</b> ADDRESS <b>Catonsville, Md.</b> 24a. REC'D BY REGISTRAR DATE <b>NOV 4 '59</b> 24b. REGISTRAR'S SIGNATURE <b>C. Shug S. Kline</b>			



11189

## CERTIFICATE OF DEATH

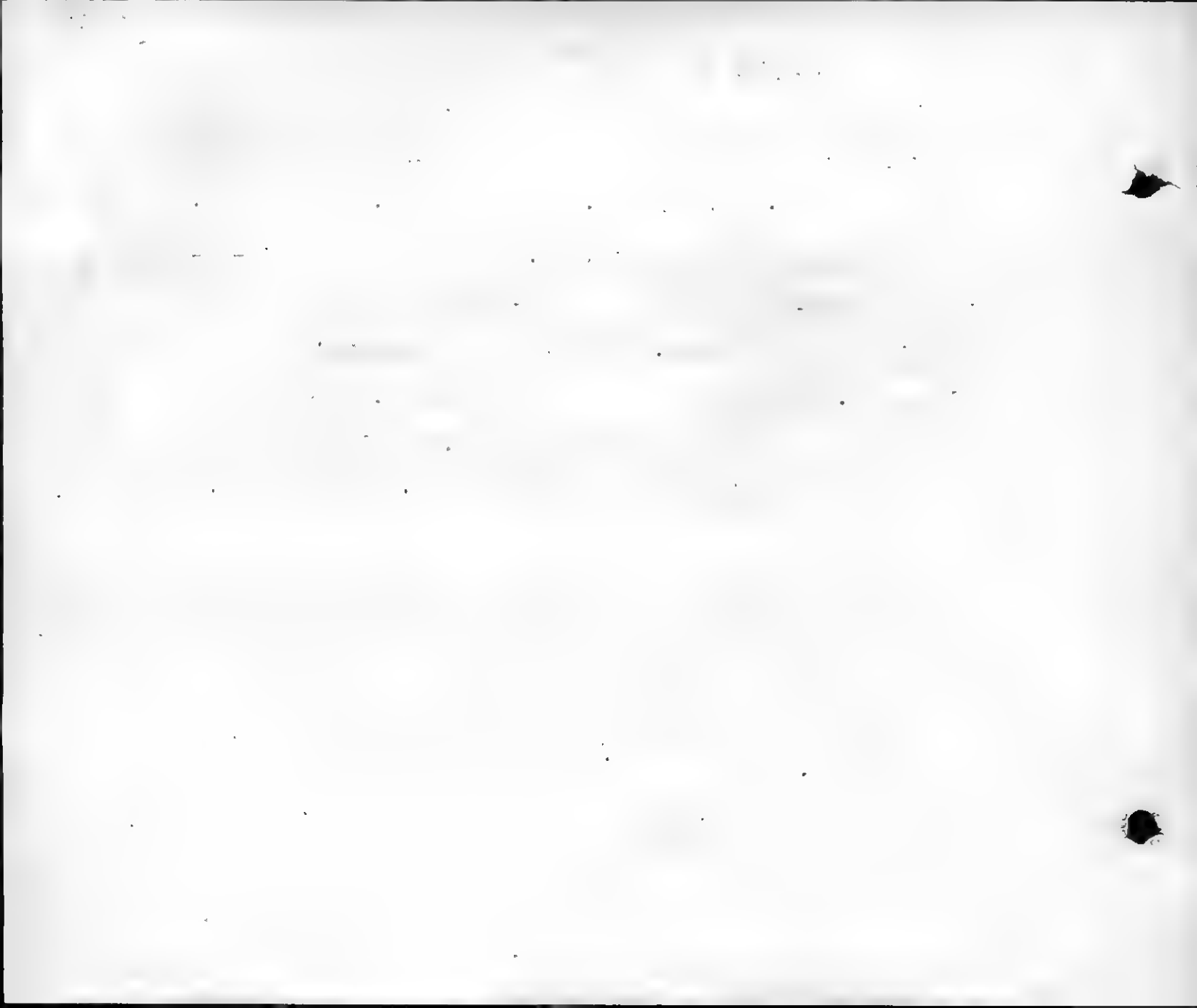
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 W. Ridgley Ave.</b>		d. STREET ADDRESS <b>120 W. Ridgley Ave.</b>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Evans Sheeler, Sr.</b>		4. DATE OF DEATH Month Day Year <b>10-25-59</b> 19	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-1893</b>
9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Water Works</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel E. Sheeler</b>		14. MOTHER'S MAIDEN NAME <b>Fanny A. Sheeler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>218-03-6442</b>	
INFORMANT <b>Samuel E. Sheeler</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/18</b> , 19 <b>56</b> to <b>10/20</b> , 19 <b>59</b> that I last saw the deceased alive on <b>10/25</b> , 19 <b>59</b> and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.		DATE SIGNED <b>10/26/59</b>	
ACTUAL SIGNATURE <b>Bennett G. Hoyer</b>		ADDRESS (Street, city or town, state) <b>1915 Seminary Ave. Baltimore</b>	
PHYSICIAN'S NAME (Type) <b>Bennett G. Hoyer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-28-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jessop Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11190

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Balto. 7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6613 Johnny Cake Rd</u>		d. STREET ADDRESS <u>6613 Johnny Cake Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry A.</u> Middle <u>S</u> Last <u>Shover</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/87</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>	IF UNDER 24 HRS Hours <u>72</u> Min. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. State</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David M. Shover</u>	
14. MOTHER'S MAIDEN NAME <u>McCauley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Mrs. Margaret V. Ebberts</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arterio Sclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Generalized Arterio Sclerosis</u> DUE TO <u>Generalized Arterio Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-1</u> , 19 <u>55</u> , to <u>10-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>59</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Howell</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore</u> DATE SIGNED <u>10-23</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/26/59</u>	<u>Woodlawn</u>	<u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Webb + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>OCT 27 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

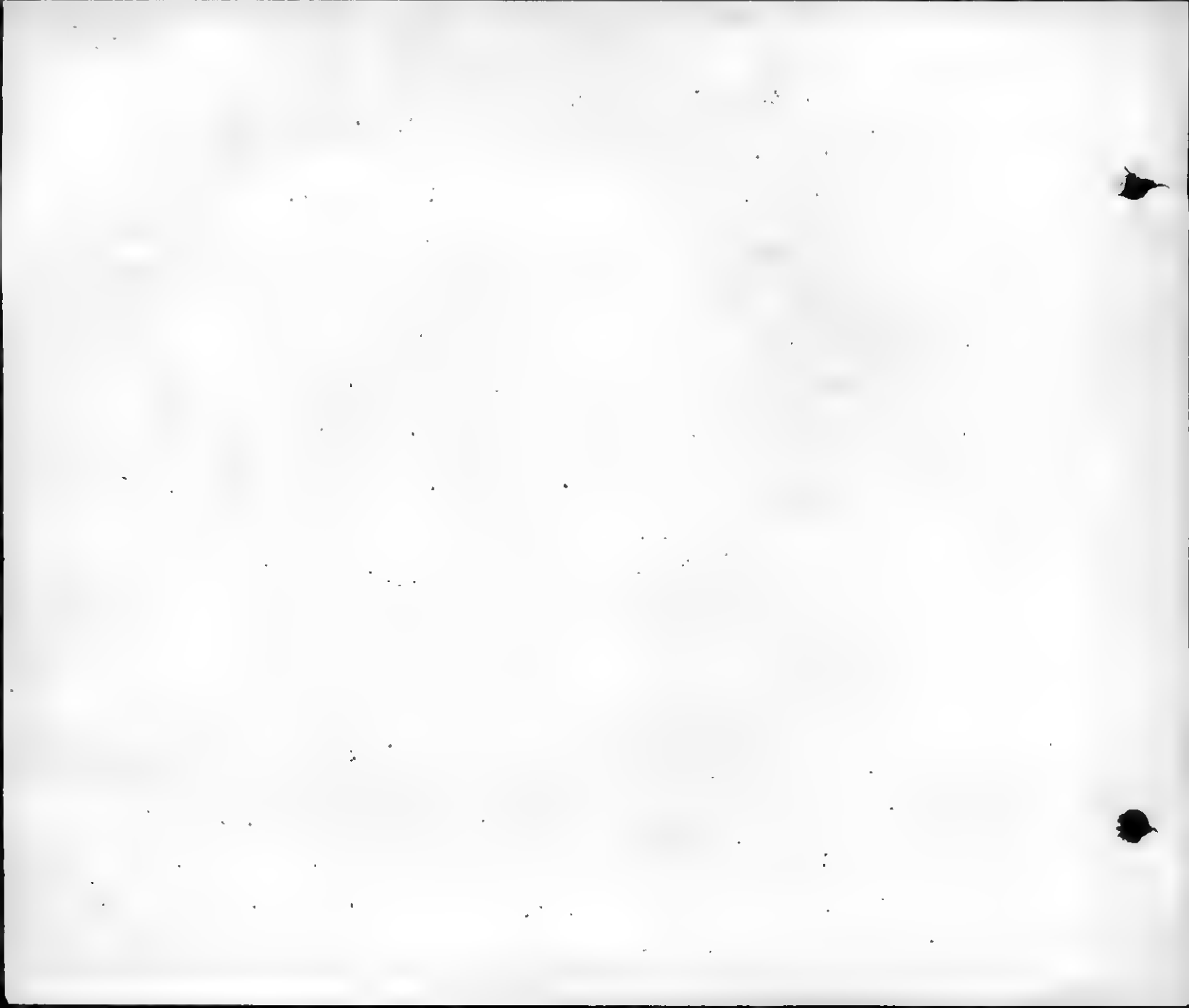
11191

CERTIFICATE OF DEATH

11167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Rosewood State Training School</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN lb <b>0, Wings Mills, Md.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Traing School</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>28-1-4</b> d. STREET ADDRESS <b>4513 Fairview ave.</b> e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First: Andrea Middle: Mae Last: Simons</b>				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/57</b>	
9. AGE (In years last birthday) <b>2</b> yrs		10. UNDER 1 YEAR Months <b>2</b> Days <b>10</b> Hours <b>19</b>		11. UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Nathan Simons</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Henrietta Coff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Rosewood Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Say - Sachs disease or influenza</b> DUE TO <b>admitted to hospital, but he</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>cerebral macular degeneration</b> DUE TO <b>malnutrition from with dehydration</b> (c) <b>due to diarrhea</b> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7/22</b> , 19 <b>59</b> , to <b>10-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-10</b> , 19 <b>59</b> , and that death occurred at <b>11:30</b> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George C. Medairy</b> M.D. <b>230 REISTERTOWN RD.</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>GEORGE C. MEDAIRY</b>				<b>REISTERTOWN, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>Removal</b>		<b>Oct 10/59</b>		<b>Philadelphia Pa</b>		<b>Philadelphia Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Lennon &amp; Sons Inc - 1124-26th North Ave</b>				24. REC'D BY REGISTRAR <b>DATE OCT 14 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

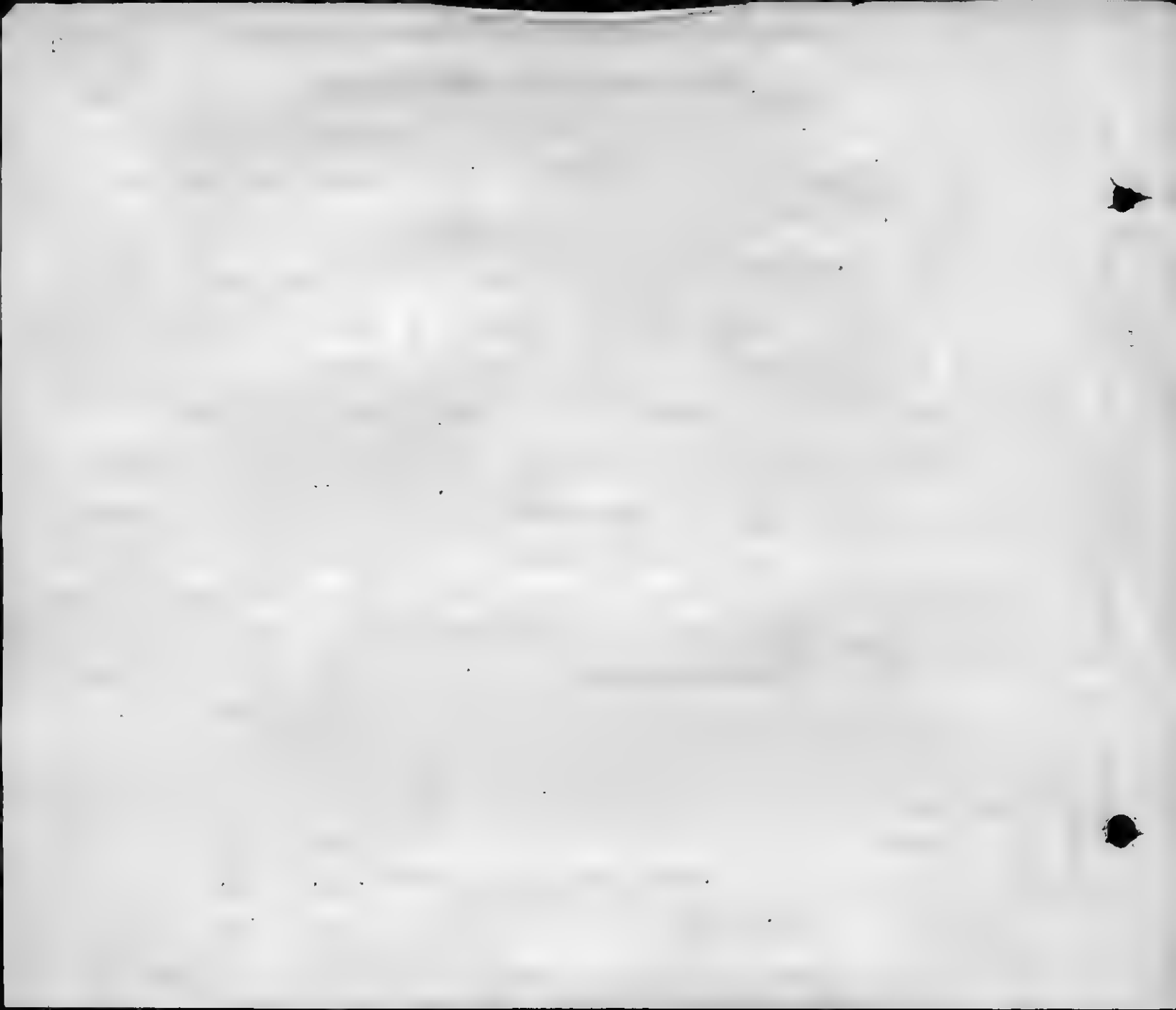
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11168

11192 **CERTIFICATE OF DEATH**

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (In this place) <u>17 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CROWNSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIE</u> (First) <u>BATTLE</u> (Middle) <u>SMITH</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Oct.</u> (Day) <u>15</u> (Year) <u>1959</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Feb 8 1909</u>	<b>9. AGE last birthday</b> <u>50</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, or retired) <u>AUTO MECHANIC</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AUTO REPAIR</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>NORTH CAROLINA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>ERNEST Z. SMITH</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY EMMA LOUIS</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>			<b>16. SOCIAL SECURITY NO.</b> <u>238-12-1500</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>022X IMMEDIATE CAUSE (A)</b> <u>Embolicism (arterial - brain)</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 hrs</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>aneurysm of thoracic aorta</u>				<u>11 7 years</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Thrombosis of thoracic aorta</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>PULMONARY TBC</u>							
<b>19a. DATE OF OPERATION</b> <u>002X</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from</b> <u>5/13, 1958</u> <b>to</b> <u>10/15, 1959</u> <b>that I last saw the deceased alive on</b> <u>10/15, 1959</u> <b>and that death occurred at</b> <u>8:05 P.</u> <b>M, from the causes and on the date stated above.</b>							
<b>ADDRESS</b> (Street, city, town, state) <u>Wm. Newcomer M.D. Superintendent, Mt. Wilson, Maryland</u> <b>DATE SIGNED</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Oct. 19, 1959</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Annapolis, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>OCT 19 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>C. J. S. Smith</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOPPING FUNERAL HOME</u> <u>172 WEST STREET</u> <u>ANNAPOLIS, MARYLAND</u>			



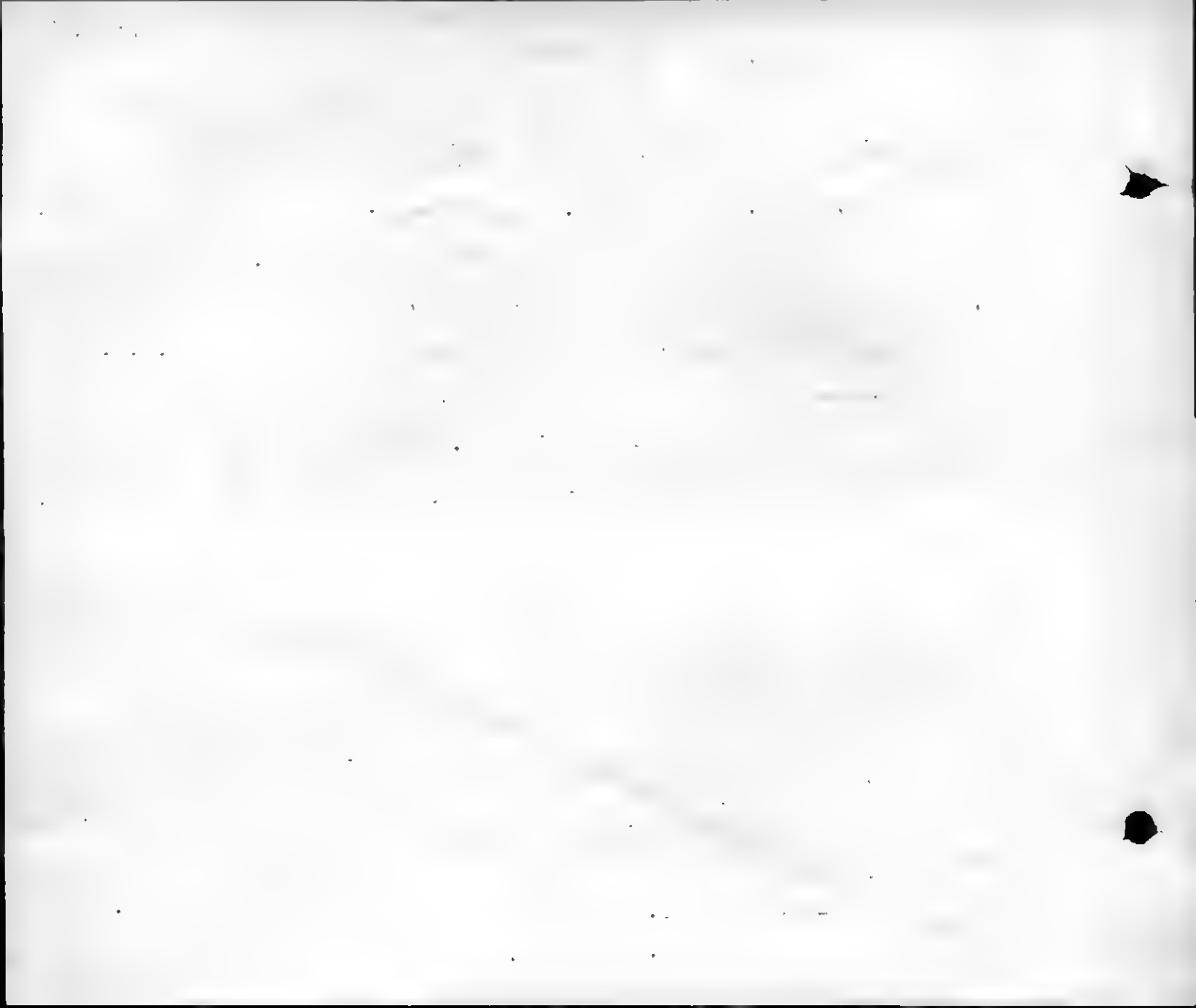
## CERTIFICATE OF DEATH

Reg. Dist. No.

11169

11193

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>Cockeysville (rural)</b> )		c. CITY OR TOWN (If outside corporate limits, write <b>White Hall</b> ) <b>Cockeysville (rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXXXXXX Big Falls Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rocco</b> Middle <b>Spera</b> Last <b>Spera</b>		4. DATE OF DEATH Month <b>Oct. 16</b> Day <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-30-1884</b>
9. AGE (In years last birthday) <b>75</b>		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>track foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>quarry</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Veto Spera</b>		14. MOTHER'S MAIDEN NAME <b>???????????</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-9500</b>	
17. INFORMANT <b>Elmer L. Mentzell</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio sclerotic C.V. Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.1</b> DUE TO (c) <b>422.1</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs/</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , to <b>Oct. 16</b> , <b>1959</b> that I last saw the deceased alive on <b>Oct. 16</b> , <b>1959</b> , and that death occurred at <b>10 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Parkton, Md.</b> DATE SIGNED <b>10/17/59</b>			
ACTUAL SIGNATURE <b>A. M. France</b> M.D.		PHYSICIAN'S NAME (Type) <b>A. M. France</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 20 '59</b>	
ADDRESS <b>Towson 4, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. K...</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Heretford</u>		d. STREET ADDRESS <u>Heretford</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Cynthia Ann Stahler</u>			4. DATE OF DEATH Month Day Year <u>Oct. 28 1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1959</u>		9. AGE (In years last birthday) yrs. <u>1</u> mos. <u>17</u> days <u>17</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>Edward Eugene Stahler</u>	14. MOTHER'S MAIDEN NAME <u>Shirley K. Kline</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>
17. INFORMANT <u>E. Eugene Stahler, Monkton, Md. R.D.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute fulminating pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐. Inspection ☒. Inquiry ☐. and find that death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined cause ☐.

ACTUAL SIGNATURE <u>A. M. France</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>10/28/59</u>
EXAMINER'S NAME (Type) <u>A. M. France</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 31, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wessups Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom Pa.</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

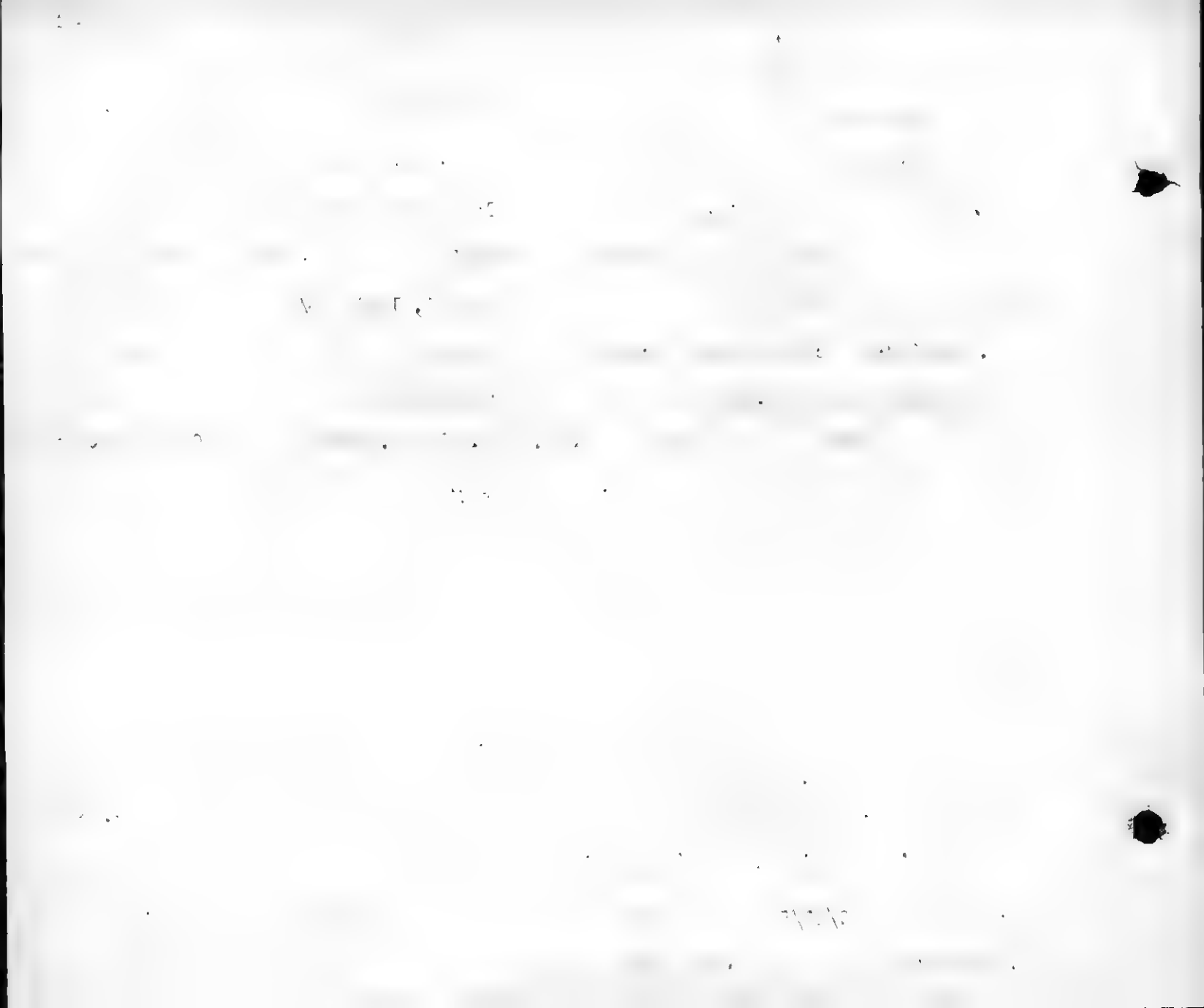
11171

11195

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Martingale Road</b>		d. STREET ADDRESS <b>106 MARTINGALE ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES GRILLEY STEVENS</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 3, 1875</b>
9. AGE (In years last birthday) yrs. <b>84</b>		10. BIRTHPLACE (State or foreign country) <b>OHIO</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. THEATRICAL DIRECTOR SELF EMPLOYED</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LAWRANCE STERN STEVENS</b>		14. MOTHER'S MAIDEN NAME <b>MATE DAVILS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. FREDERICK S. MATTHEWS</b>		Address <b>106 MARTINGALE RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC CIRCULATORY DISEASE</b> <b>34X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1957</b> to <b>02-25-1959</b> , that I last saw the deceased alive on <b>OCT 23, 1959</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>TOWSON, MD.</b> DATE SIGNED <b>10-24-59</b> ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D. PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>10/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN BURNS SONS</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 30 '59</b>	
ADDRESS <b>TOWSON, MD</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. House</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



## CERTIFICATE OF DEATH

Reg. Dist. No.

11025

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5575 Ashbourne Rd.</b>		d. STREET ADDRESS <b>5575 Ashbourne Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>AMELIA</b> First Middle Last		4. DATE OF DEATH Month <b>Oct.</b> Day <b>7,</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>August Buck</b>		14. MOTHER'S MAIDEN NAME <b>Louise Koss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Carrie Hile - 5575 Ashbourne Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>arterial hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>at home</b> DUE TO <b>General arteriosclerosis</b> (c) <b>General arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 da</b> <b>10 4 10</b> <b>9 6 da</b> <b>3 4 10</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 19 <b>50</b> , to <b>Oct 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 7</b> , 19 <b>59</b> , and that death occurred at <b>4 45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1609 Main St</b> DATE SIGNED <b>Oct 7 1959</b>			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.		DATE SIGNED <b>Oct 7 1959</b>	
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		DATE SIGNED <b>Oct 7 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Vickers</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11196

CERTIFICATE OF DEATH

11173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>7 YEARS</b>		d. STREET ADDRESS <b>1808 BARCLAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>ANNA</b> Last <b>STUPKA</b>		4. DATE OF DEATH Month <b>OCT</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-3-1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>CRIS FISHER</b>		14. MOTHER'S MAIDEN NAME <b>HETTY SWARTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-2</b> , 19 <b>52</b> , to <b>10-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-14</b> , 19 <b>59</b> , and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter T. Kues</b>		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>	
DATE SIGNED <b>10/14/59</b>		M. D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/19/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Natl</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul St.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kues</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

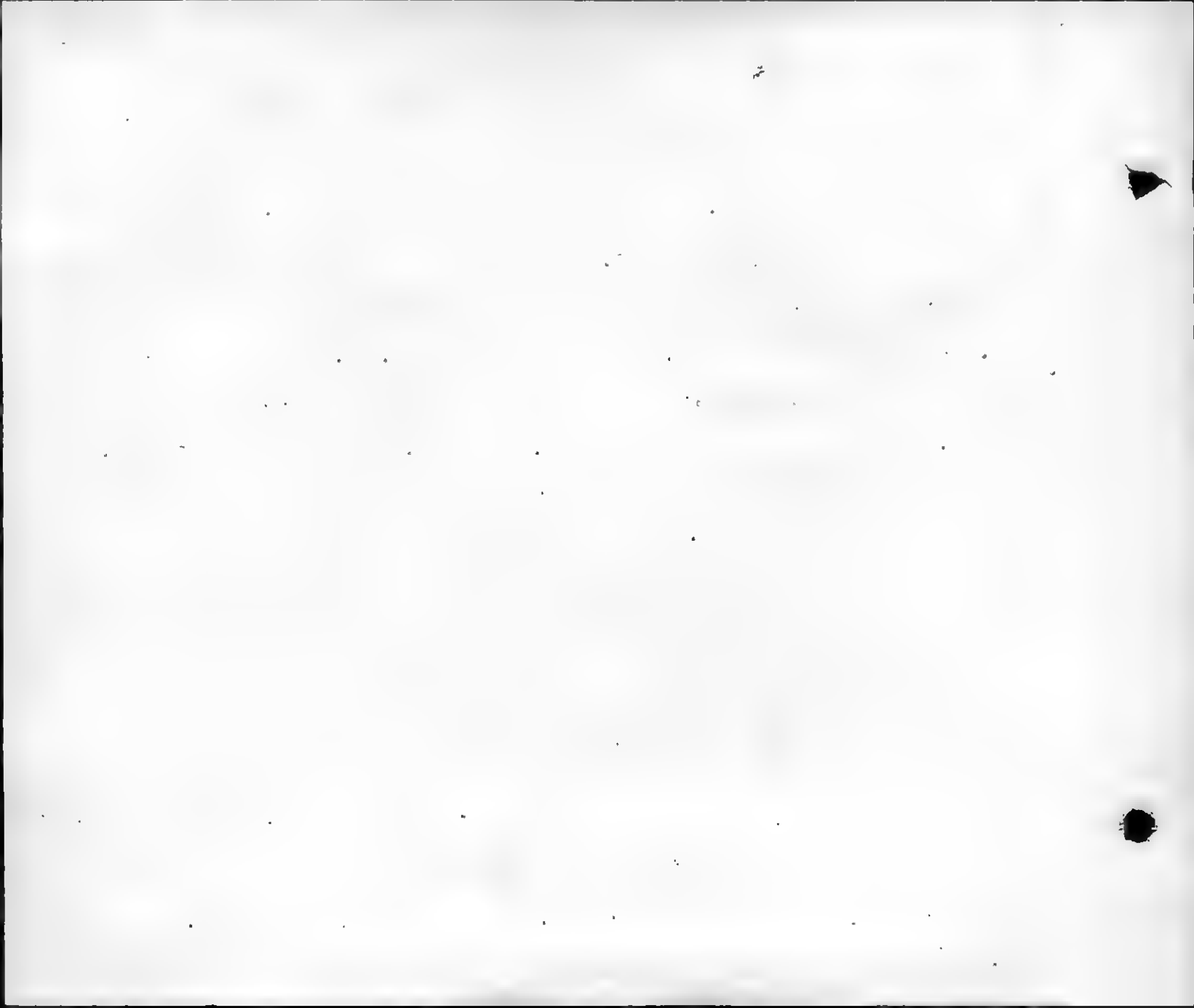
Reg. Dist. No.

11197

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4333 Chapel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William C. Sweetman</u>		4. DATE OF DEATH Month Day Year <u>October 5, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1888</u>
9. AGE (In years lost birthday) yrs. <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist-Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert A. Sweetman</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Mr. William C. Sweetman 4333 Chapel Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1957</u> , to <u>Oct. 5, 1959</u> , that I last saw the deceased alive on <u>Oct. 3, 1959</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adam G. Swiss</u>		DATE SIGNED <u>Oct. 7, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Adam G. Swiss</u>		ADDRESS (Street, city or town, state) <u>6232 BELAIR ROAD, BALTOE MD.</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-8-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Tamm</u>	
ADDRESS <u>7401 Belair Rd.</u>		DATE <u>OCT 9 '59</u>	

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

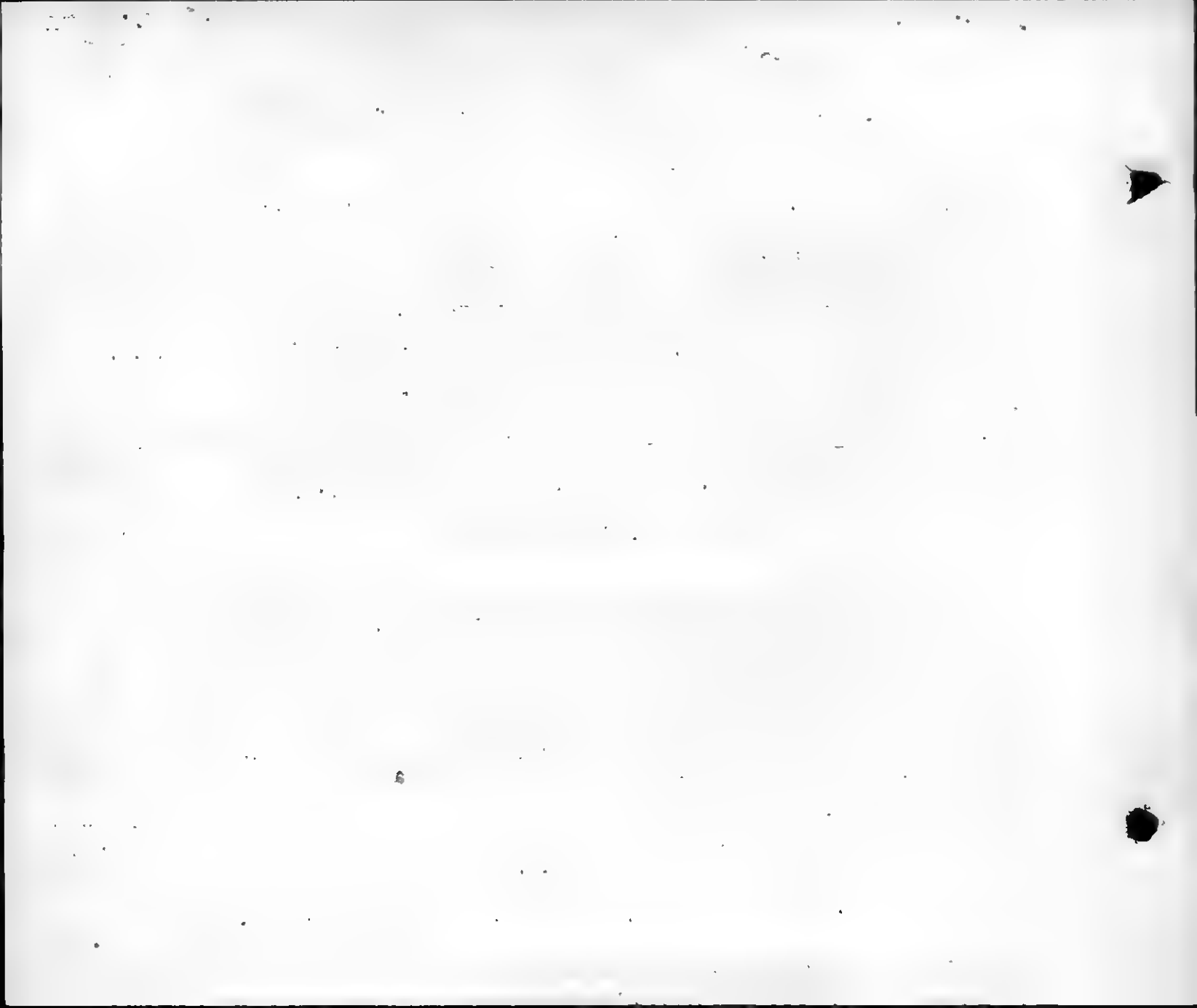


CERTIFICATE OF DEATH

Reg. Dist. No. 11175

11198

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
c. LENGTH OF STAY IN lb <b>25 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>755 W LEXINGTON STREET</b>	
3. NAME OF DECEASED (Type or print) <b>Served as: Norman L TAYLOR</b>		4. DATE OF DEATH <b>OCTOBER 10, 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>6-22-95</b>	9. AGE (In years last birthday) <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER COMPANY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM LANE</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA TAYLOR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>212-07-5097</b>	
17. INFORMANT <b>CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE MURAL THROMBUS OF THE LEFT VENTRICLE</b> 434.4 DUE TO <b>HYPERTROPHY AND DILATATION OF THE HEART</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b> (c)			
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PASSIVE CONGESTION OF THE LUNGS, LIVER AND INTESTINES</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that VA attended the deceased from <b>September 15 1959</b> to <b>October 10, 1959</b> that the deceased died on <b>October 10, 1959</b> and that death occurred at <b>3:40 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harold Calvo</b>		DATE SIGNED <b>10-10-59</b>	
PHYSICIAN'S NAME (Type) <b>Harold Calvo</b>		M.D. <b>VAH Baltimore Md Ft Howard Div. 10-10-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/14/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	
ADDRESS <b>1808-10 N Monroe St Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. John S. Kraus</b>	



11026

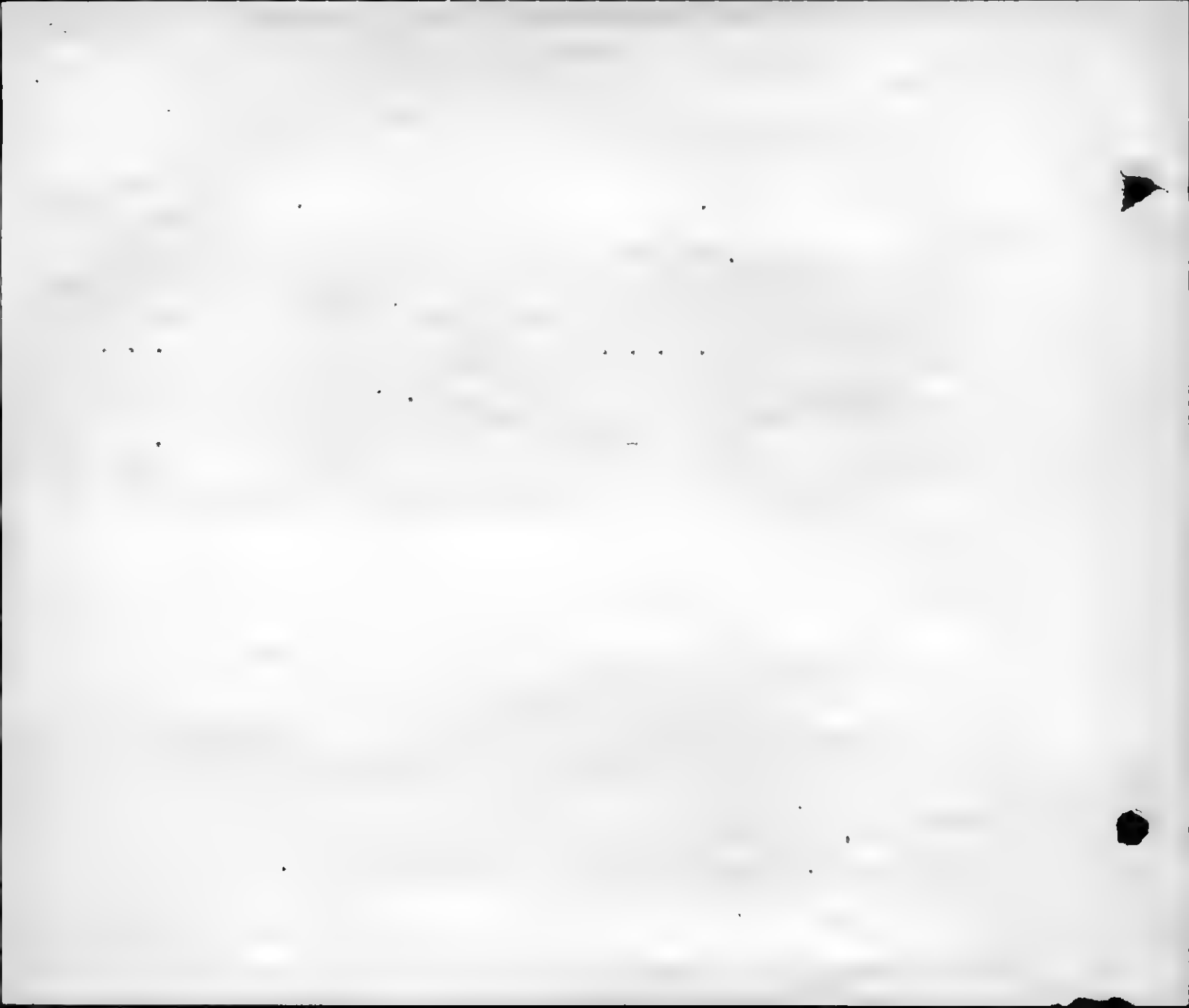
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4900 Leeds Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jerome G. Tegeler</u>		4. DATE OF DEATH Month Day Year <u>October 19, 1959</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.&amp;O.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Tegeler</u>		14. MOTHER'S MAIDEN NAME <u>Mary D. Echle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO <u>705-09-2708</u>	
17. INFORMANT <u>Edna Granlund</u>		Address <u>4900 Leeds Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>356.1 Amyotrophic Lateral Sclerosis</u> DUE TO (b). <u>Multiple Neuritis</u> DUE TO (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u> <u>7 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>53</u> , to <u>Oct 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 19</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>4201 Wilkens Ave. Baltimore 29, Md</u> DATE <u>10/20/59</u>			
ACTUAL SIGNATURE <u>John F. Coolahan</u>		M.D. <u>4201 Wilkens Ave. Baltimore 29, Md</u>	
PHYSICIAN'S NAME (Type) <u>John F. Coolahan</u>		<u>4201 Wilkens Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore Maryland</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrace, Inc. 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carl S. Thoma</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11177

11199

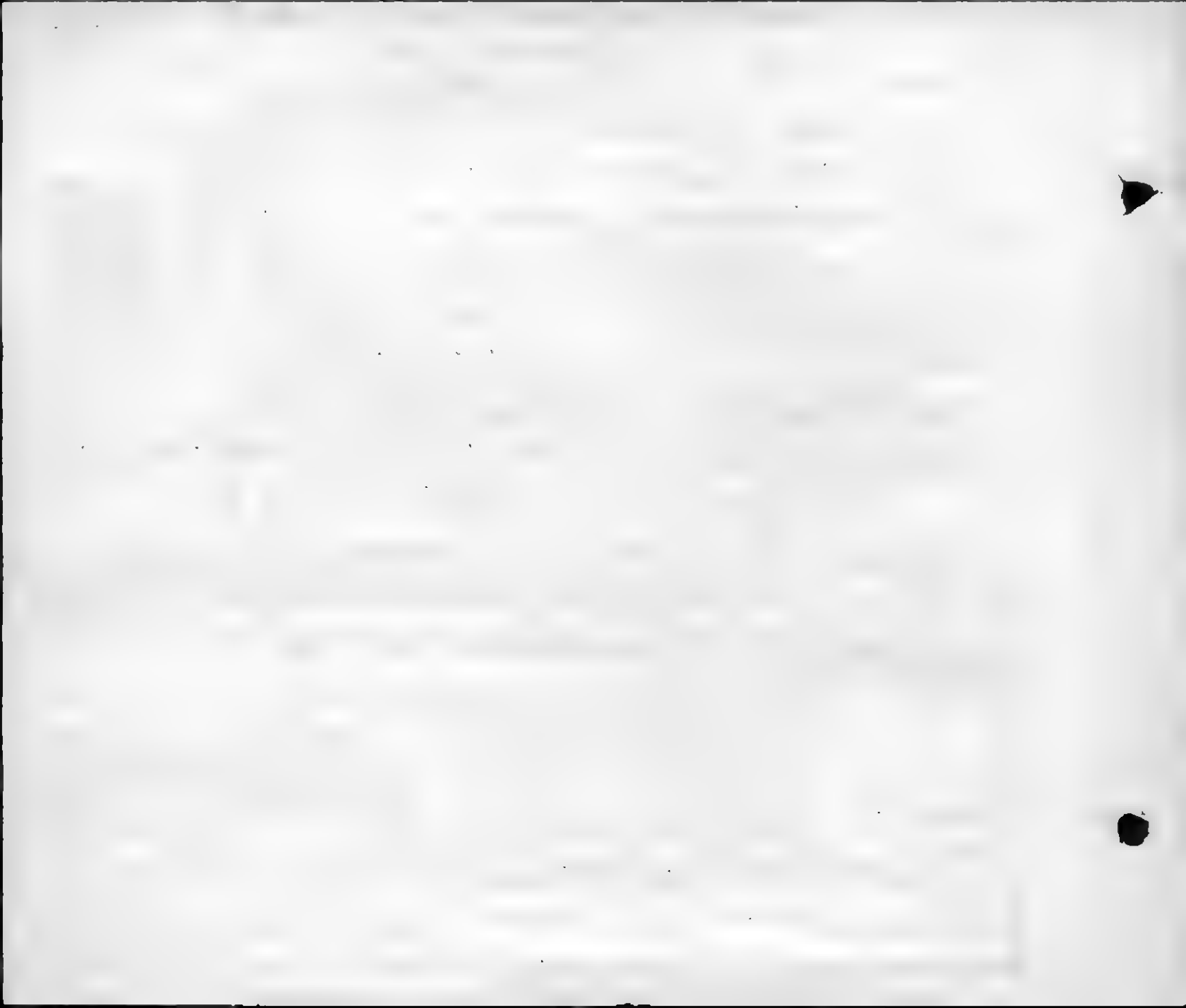
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT WHARTON TEST</b>				4. DATE OF DEATH Month Day Year <b>October 19 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1874</b>	
9. AGE (In years last birthday) yrs. <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Statistician</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis Wilby Test</b>				14. MOTHER'S MAIDEN NAME <b>Julia Crawley Ellis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-8554</b>		17. INFORMANT <b>Eugene Wharton Test - 300 Montrose Ave. - 28</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>COR PULMONALE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>EMYSEMA, CHRONIC</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN ESSENTIAL HYPERTENSION</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b> <b>5 YRS.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT. 30, 1956</b> to <b>OCT. 19, 1959</b> , that I last saw the deceased alive on <b>OCT. 19, 1959</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>5334 LIBERTY HEIGHTS AVE. BALTIMORE 7, MD</b> DATE SIGNED							
ACTUAL SIGNATURE <b>MARVIN GOLDSTEIN</b>		PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/22/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>				ADDRESS <b>4600 Liberty Hghts. Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

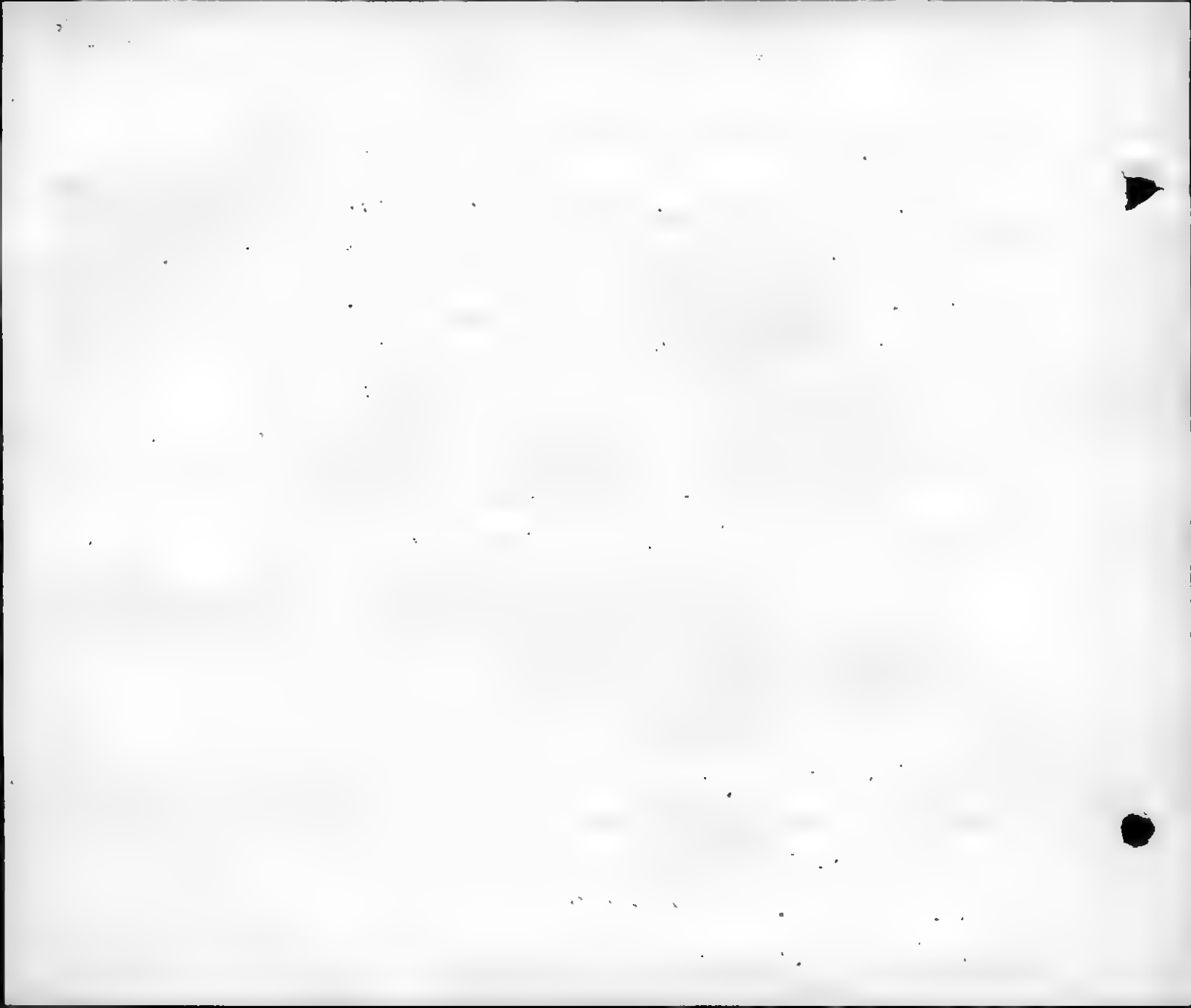
11200

## CERTIFICATE OF DEATH

11178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 ESSEX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1109 N. MARLYN AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELDORA E. TICHNOR</b>		4. DATE OF DEATH Month Day Year <b>OCT. 21 ST 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 8-1893</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MAINE</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>LEONARD HEATH</b>		14. MOTHER'S MAIDEN NAME <b>LENORA ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <input type="checkbox"/>	
INFORMANT Address <b>WALTER L. CARPENTER - SAME AS ABOVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>10 yrs. 10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1957</b> to <b>OCT 21</b> , 1959, that I last saw the deceased alive on <b>OCT 14</b> , 1959, and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert J. Lyden</b> M.D.		ADDRESS (Street, city or town, state) <b>Essex Md.</b> DATE SIGNED <b>OCT 23/59</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>OCT. 23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>		22d. LOCATION (City, town, or county) (State) <b>Enterprise N. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connolly - 418 Eastern Ave Essex</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 27 '59</b>	
ADDRESS <b>418 Eastern Ave Essex</b>		24b. REGISTRAR'S SIGNATURE <b>C. P. Tuma</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11201

### CERTIFICATE OF DEATH

11179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elsie Harris Tracy</u>				4. DATE OF DEATH <u>October 28 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 June 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Baltco, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Pleasant Tolson</u>				14. MOTHER'S MAIDEN NAME <u>Belle Bosley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>203-24-9263</u>		17. INFORMANT <u>Mrs. George Lees, Cockeysville Md.</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> (b) <u>Hypertension on atherosclerotic basis</u> (c) <u>30 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>Aug 19 1959</u>				20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 19 1959</u> to <u>Oct 28 1959</u> , that I last saw the deceased alive on <u>20 Oct 1959</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Lees</u> M.D.				ADDRESS (Street, city or town, state) <u>Cockeysville Md</u> DATE SIGNED <u>28 Oct 59</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. LEES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 31 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u> ADDRESS				24. REC'D BY REGISTRAR <u>NOV 2 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11180

Reg. Dist. No.

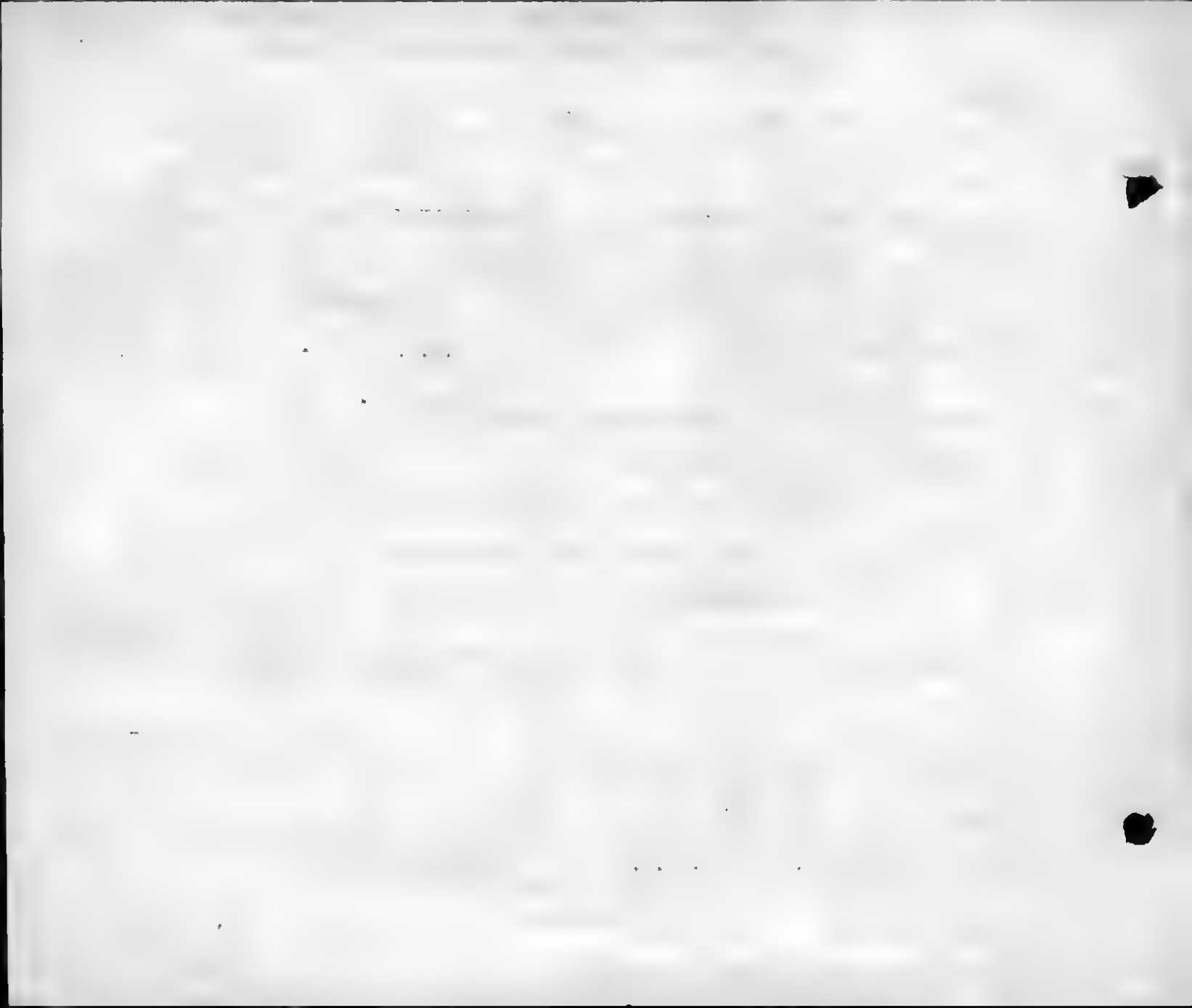
11202

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3yr 2mo</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>			
f. STREET ADDRESS <b>315 E. Jefferson</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Beryl</b> Middle <b>(Maude)</b> Last <b>TREADWAY</b>				4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/89</b>	
9. AGE (In years last birthday) <b>2080x(1)80 79</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b>		11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>10</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>xxxxxx</b>			
11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>U,S,A,</b>			
13. FATHER'S NAME <b>Moses Hinds Powder</b>				14. MOTHER'S MAIDEN NAME <b>Algeria V. Powder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Foreign body in bronchus (aspirated food)</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>921.7</b> (a), stating the underlying cause last. (c) <b>Generalized arteriosclerosis; senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis; senility</b>							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Choked while eating meal and shortly expired</b>					
20c. TIME OF INJURY Month, Day, Year <b>10/24 1959</b> Hour <b>5:45</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Diningroom</b>		20f. (City or town) (County) (State) <b>Catonsville-Baltimore-Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.K. Moore &amp; Son</b>				ADDRESS <b>301 N. Carroll St</b>		24c. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>William S. Thayer</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11181

Reg. Dist. No.

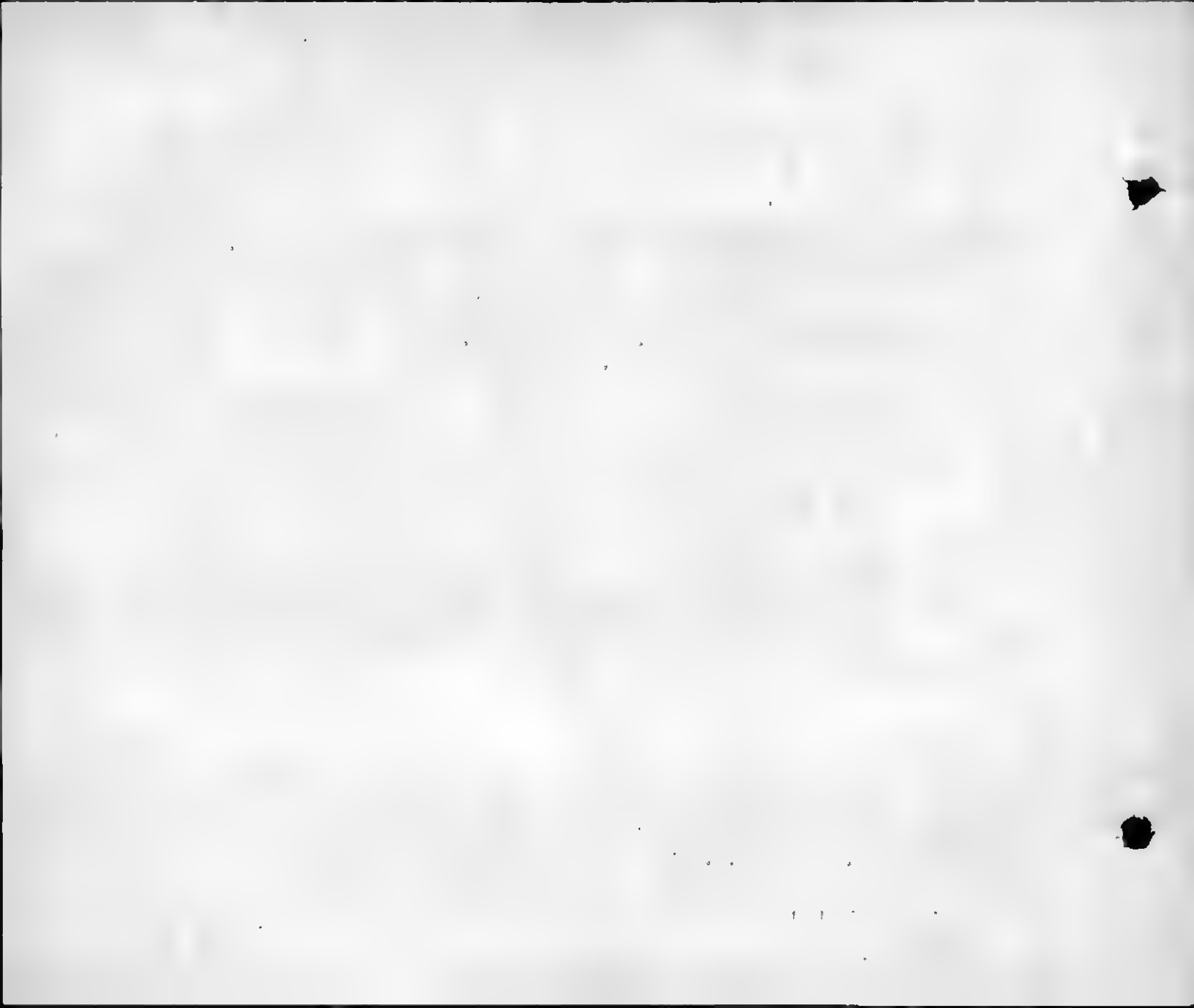
11027

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1233 Greystone Rd.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <b>1233 Greystone Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George Frederick</b> Middle <b>Miller</b> Last 4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1909</b>				5. SEX <b>M</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Nov. 24, 1888</b> 9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glenn F. Gall</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glenn F. Gall</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown Treibler</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Hoffman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>18</b>		17. INFORMANT <b>Mrs. A Leo Macer</b> Address <b>1233 Greystone Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4 a.u.</b> DUE TO <b>Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George S.M. Kieffer MD</b>				DATE SIGNED <b>Oct. 1, 1909</b>			
EXAMINER'S NAME (Type) <b>George S.M. Kieffer MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue</b>				24a. REC'D BY REGISTRAR <b>OCT 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the State, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11203 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

11182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Balt.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutheville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt. 14</u>	
c. LENGTH OF STAY in 1b <u>2 days</u>		d. STREET ADDRESS <u>3020 Roselawn Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Tyler</u> Last <u>Tyler</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamship Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Wallace Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Hester Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. J. F. Wittstruck</u>		Address <u>3020 Roselawn Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>  <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion; cancer prostate; diabetes</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>Oct. 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>October 10</u> , 19 <u>59</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10-11-59</u> ACTUAL SIGNATURE <u>Ronald Jandorf</u> M.D. PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>10-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanes</u>



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11183

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b> c. LENGTH OF STAY IN IS <b>16 1/4 HRS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2909 Liberty Parkway</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b> d. STREET ADDRESS <b>2909 Liberty Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUTH RICHARDSON VAN DYKE</b>		4. DATE OF DEATH <b>October 23 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 19, 1914</b>
9. AGE (in years last birthday) <b>45</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or years if retired) <b>SALES LADY</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN G. RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>ELLA L. COMPTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>394-24-7049</b>	
17. INFORMANT <b>JOHN J. RICHARDSON, ELLICOTT CITY, MD.</b>		Address <b>60 MAIN ST</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease, marked</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b> M.D. EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b> DATE SIGNED <b>10/23/59</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>10/27/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL</b> 22d. LOCATION (City, town, or country) (State) <b>BLUEFIELD, VA.</b> 23. FUNERAL DIRECTOR <b>Walter L. Bradley, Newmarket, Md.</b> 24a. REC'D BY REGISTRAR <b>OCT 26 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11204

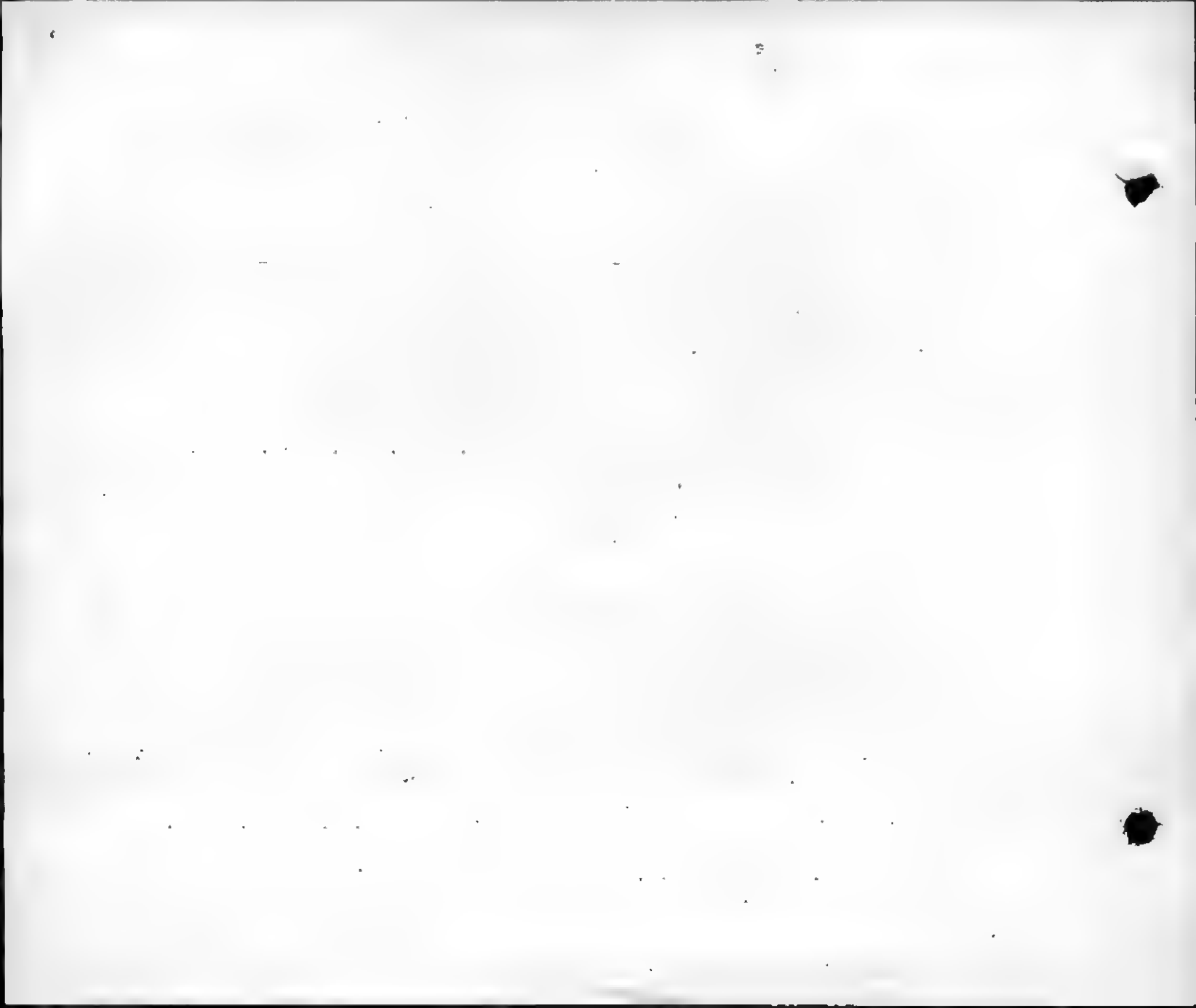
## CERTIFICATE OF DEATH

Reg. Dist. No. 11184

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3200 Clifton Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>WADE</b> Last <b>WADE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1924</b>
9. AGE (in years lost birthday) <b>35 yrs</b>		10. IF UNDER 1 YEAR: Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min. <b>35</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Gaston, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee Wade</b>		14. MOTHER'S MAIDEN NAME <b>Bertha (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>217-12-9368</b>	
17. INFORMANT <b>Clin Rec., Vet. Adm. Hosp. Ft Howard, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO <b>PYELONEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>CARDIOMEGLY</b> DUE TO (b) <b>CARDIOMEGLY</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>2 years</b> <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>VA</b> Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 23 19 59</b> to <b>October 23 19 59</b> and that death occurred on the date stated above. <b>3:30AM</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		ADDRESS (Street, city or town, state) <b>VAH BALTO MD., FT HOWARD DIV.</b> DATE SIGNED <b>10/23/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH BALTO MD., FT HOWARD DIV</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-27-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Kelson</b> ADDRESS <b>1348 Calhoun St. Balto. Md</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kneiss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

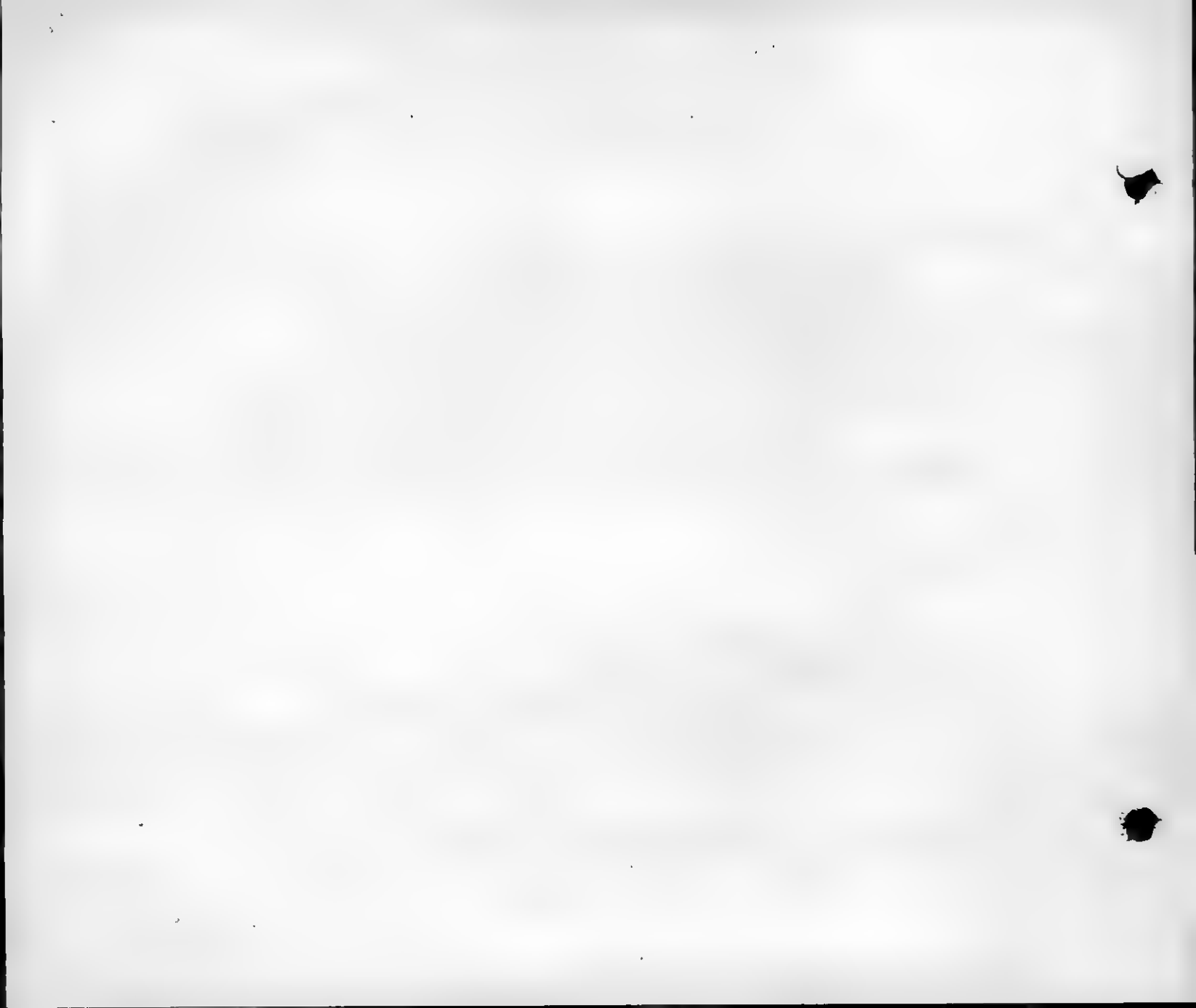
11205

CERTIFICATE OF DEATH

Reg. Dist. No.

11185

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lutherville</u>		c. LENGTH OF STAY IN 1b <u>53 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Green Spring Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E.</u> Last <u>Wadsworth</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel W. Wadsworth</u>		14. MOTHER'S MAIDEN NAME <u>Alice Forwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-4110A</u>	
17. INFORMANT <u>Mrs Wadsworth Lutherville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Hypertensive CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> (c) <u>Arteriosclerosis, generalized</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 pm</u> , 1950, to <u>Oct 24</u> , 1959, that I last saw the deceased alive on <u>Oct 24</u> , 1959, and that death occurred at <u>Lt 2A M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1632 Reisterstown Road</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT-25-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SATER'S BAPTIST</u>	22d. LOCATION (City, town, or county) (State) <u>FALLS RD LUTHERVILLE - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Townson-Mc-Townson 4-MD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>			





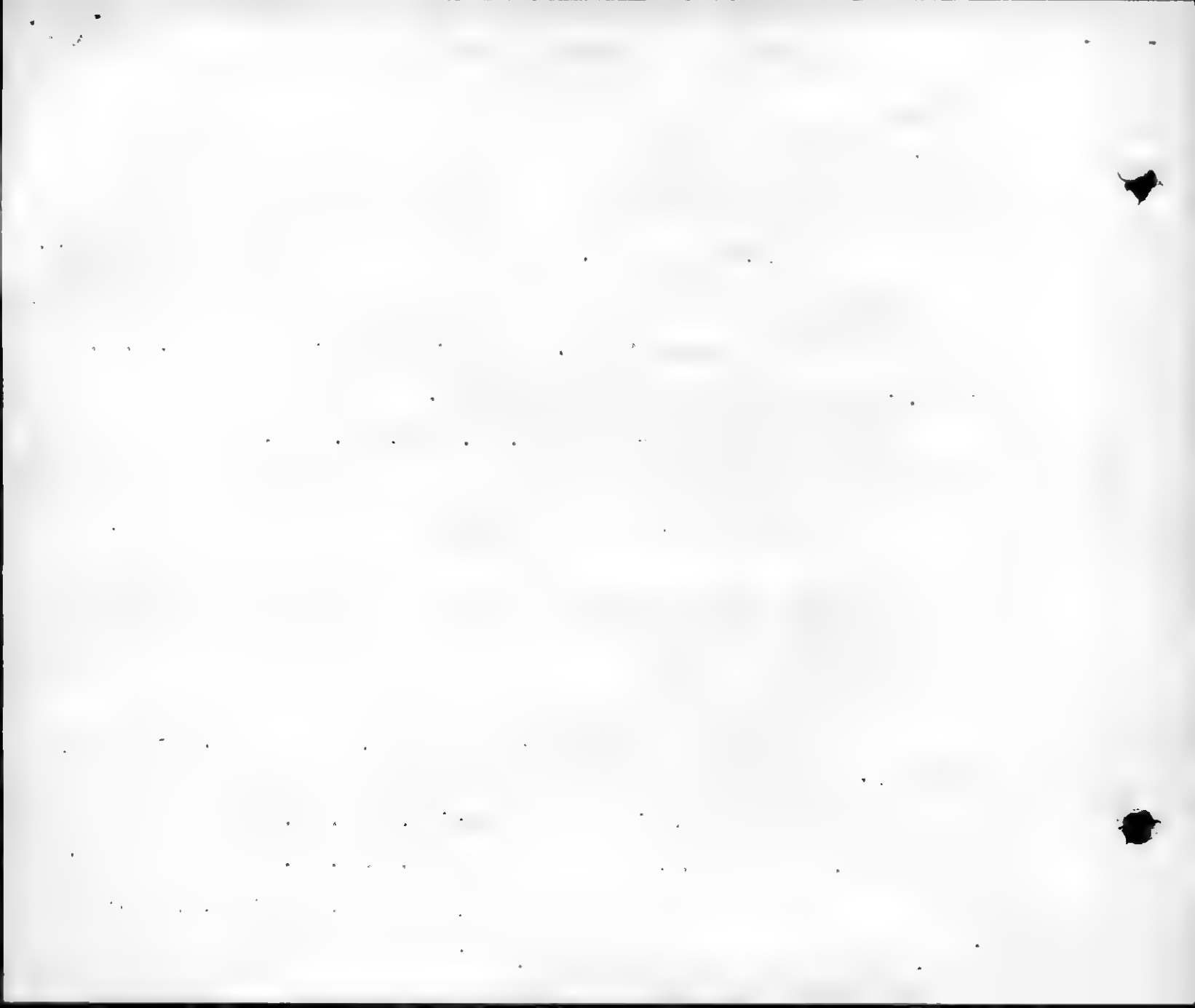
11206

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3 VAN-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>23 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE T. WAGENER</b>				4. DATE OF DEATH Month Day Year <b>October 21 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 23, 1922</b>	
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fabricator Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Henry A. Wagener</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Grace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>217-16-7519</b>			
17. INFORMANT <b>Clin. Rec., VAH, Balto. 18, Md.</b>				Address <b>FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC GLOMERULONEPHRITIS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTO. 18, MD.</b>	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>September 28 1959</b> to <b>October 21 1959</b> , and that death occurred at <b>1:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John W. Crawford</i>				ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				DATE SIGNED <b>10/22/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Park (Baltimore)</b>	
22d. LOCATION (City, town, or county) <b>Dorsey, Maryland</b>				22e. (State) <b>Md.</b>		22f. (County) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George L. Schwab</i>				ADDRESS <b>2101 Frederick Ave. Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 26 1959</b>	
24b. REGISTRAR'S SIGNATURE <i>Christina A. Thomas</i>				24c. REGISTRAR'S NAME <b>Christina A. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11207

CERTIFICATE OF DEATH

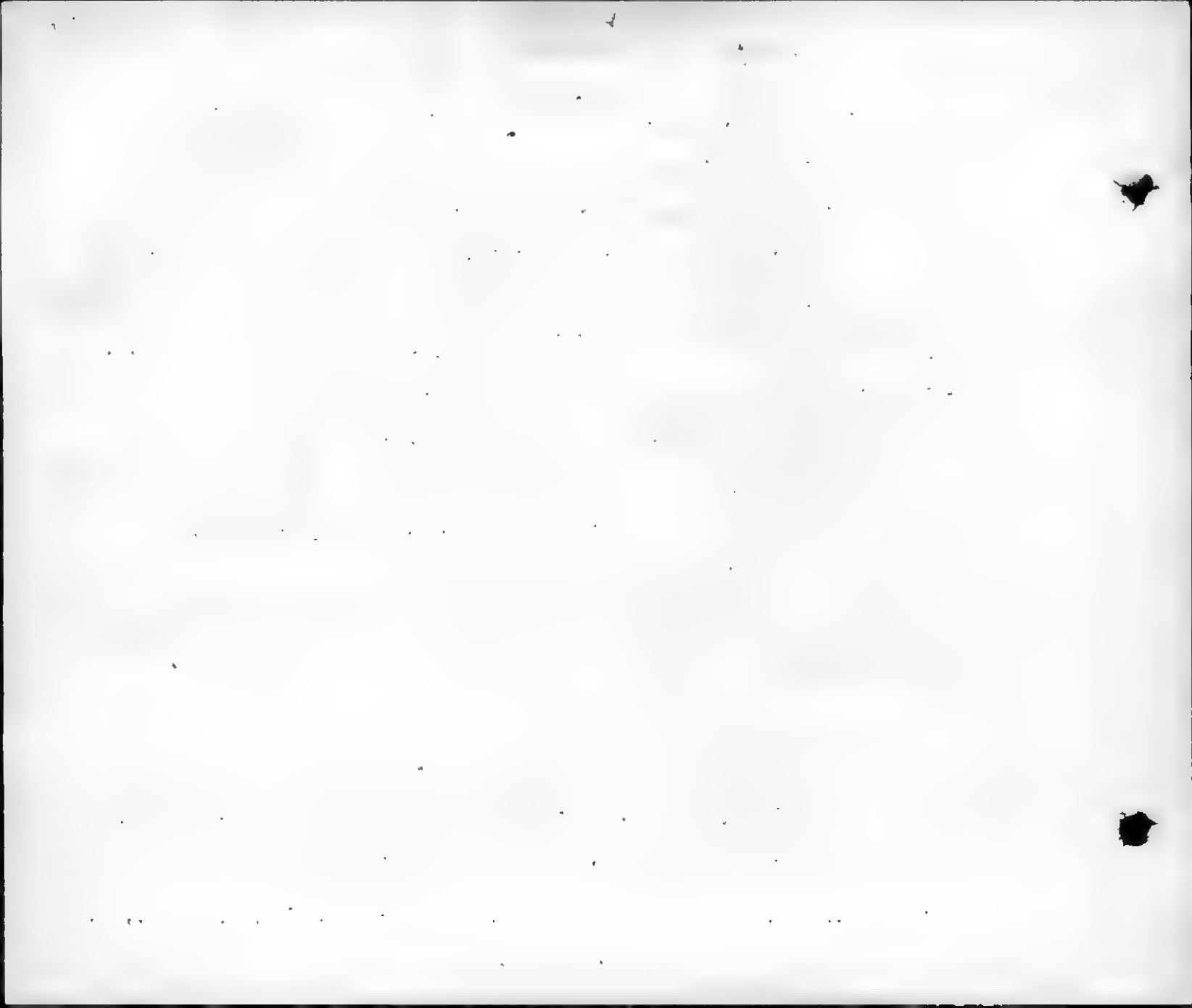
11187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN 1b <b>Linthicum Heights, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		d. STREET ADDRESS <b>701 Shipley Court</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Lester</b> Last <b>Warnken</b>		4. DATE OF DEATH Month <b>10</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/16/59</b>
9. AGE (In years last birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.	11. IF UNDER 24 HRS Hours <b>8</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Stewart Warnken</b>	
14. MOTHER'S MAIDEN NAME <b>Lillian Mary Fowler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> If yes, give war or dates of service	
16. SOCIAL SECURITY NO. <b>—</b>		Address <b>Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia complicated</b> DUE TO (b) <b>by aspiration of stomach content</b> DUE TO (c) <b>Hydrocephalus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1959</b> to <b>1959</b> , that I last saw the deceased alive on <b>1959</b> , and that death occurred at <b>2:15</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter W. Rieckert</b>		ADDRESS (Street, city or town, state) <b>4307 Mainfield Ave 1025-59</b>	
PHYSICIAN'S NAME (Type) <b>Peter W. Rieckert</b>		DATE SIGNED <b>Baltimore, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ritchie Hg. A. A. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Jones</b>		ADDRESS <b>4001 Ritchie Hwy</b>	
24a. REC'D BY REGISTRAR <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlando S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11208

CERTIFICATE OF DEATH

Reg. Dist. No.

11188

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>604 North Bend Road</u>		d. STREET ADDRESS <u>604 North Bend Road</u>	
3. NAME OF DECEASED (Type or print) <u>MARY ROSE WARTHEN</u>		4. DATE OF DEATH <u>Oct 8 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>12</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Emmitsburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hoke</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Shorb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown <input type="checkbox"/> If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-10498</u>	
17. INFORMANT <u>Francis X. Warthen Sr.</u>		Address <u>604 North Bend Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic CVD</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>Oct 8 1959</u> , that I last saw the deceased alive on <u>Oct 6 1959</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.		ADDRESS (Street, city or town, state) <u>5305 East Dime</u> DATE SIGNED <u>10/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		<u>Baltimore - 27, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 12 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Geyfel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11209

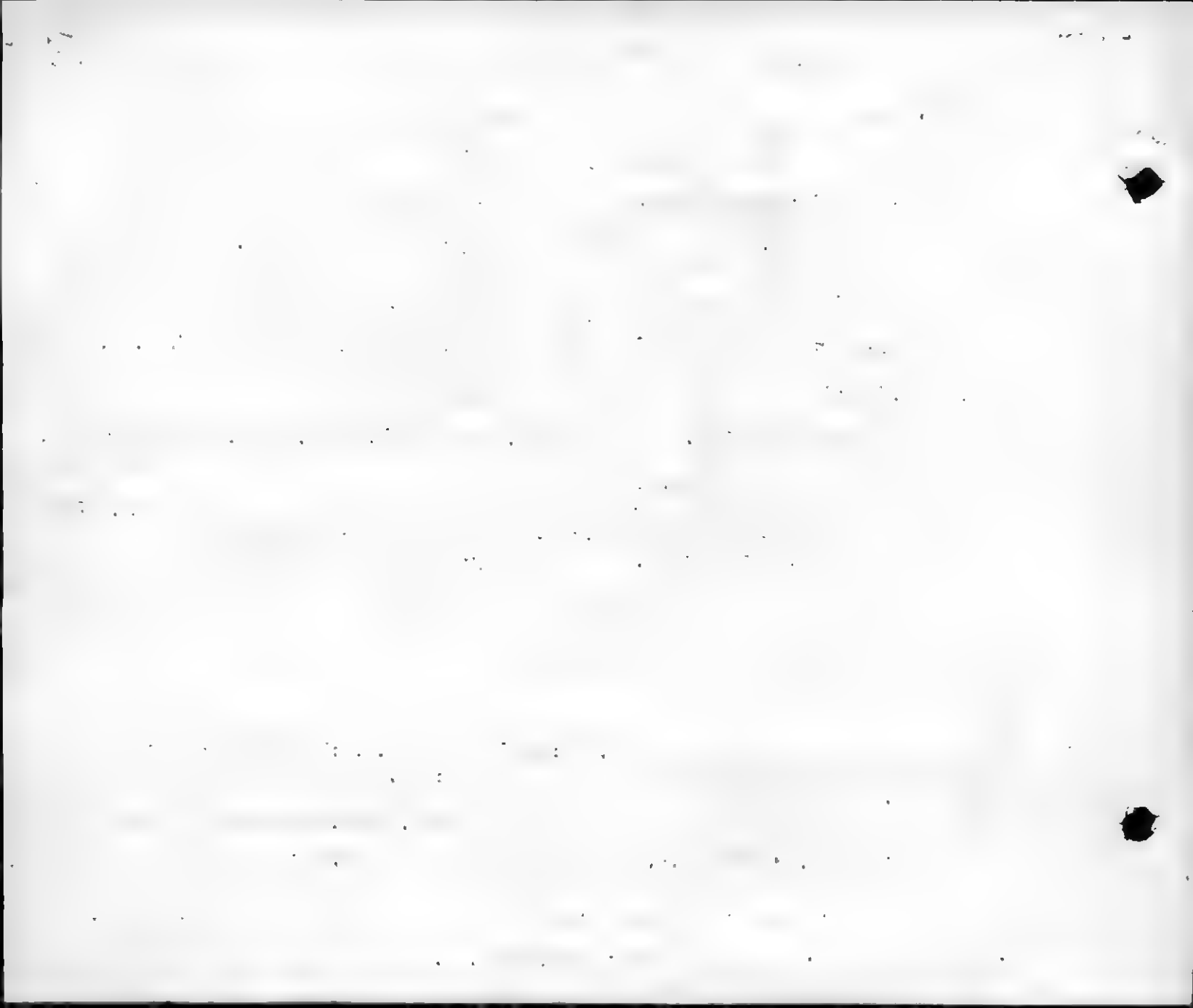
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Minutes</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		d. STREET ADDRESS <b>3640 Keystone Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>ANDREW</b>		Middle <b>WASSIL</b>		Last <b>WASSIL</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>6</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 16, 1933</b>		9. AGE (In years last birthday) <b>26</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tractor Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Hazleton, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Andrew G. Wassil</b>				14. MOTHER'S MAIDEN NAME <b>Helen Novak</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give no. or date of service) <b>12/5/51-2/3/55 212 30 8035</b>				INFORMANT <b>Clin. Records, VAH, Balto. 18, Md. Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <b>CAUSE OTHER THAN TRAUMA</b> DUE TO <b>MALIGNANT TUMOR OF LEFT UPPER LOBE, WITH SPREAD</b> DUE TO <b>CHEST WALL, MEDIASTINUM AND RIGHT LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH <b>SEV. HOURS</b> <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>VA</b> attended the deceased from <b>Oct. 6, 1:12AM 1959</b> to <b>Oct. 6, 1:17AM 1959</b> and that death occurred at <b>1:17AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE <i>Norris L. Newton</i>				M.D. <b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION 10/6/59</b>							
PHYSICIAN'S NAME (Type) <b>NORRIS L. NEWTON, M.D.</b>				VAH, BALTO 18, MD. FORT HOWARD DIVISION 10/6/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 9, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donovan Funeral Home, 37 3818 Roland Ave. Balto. Md.</b>				ADDRESS <b>3818 Roland Ave. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kram</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

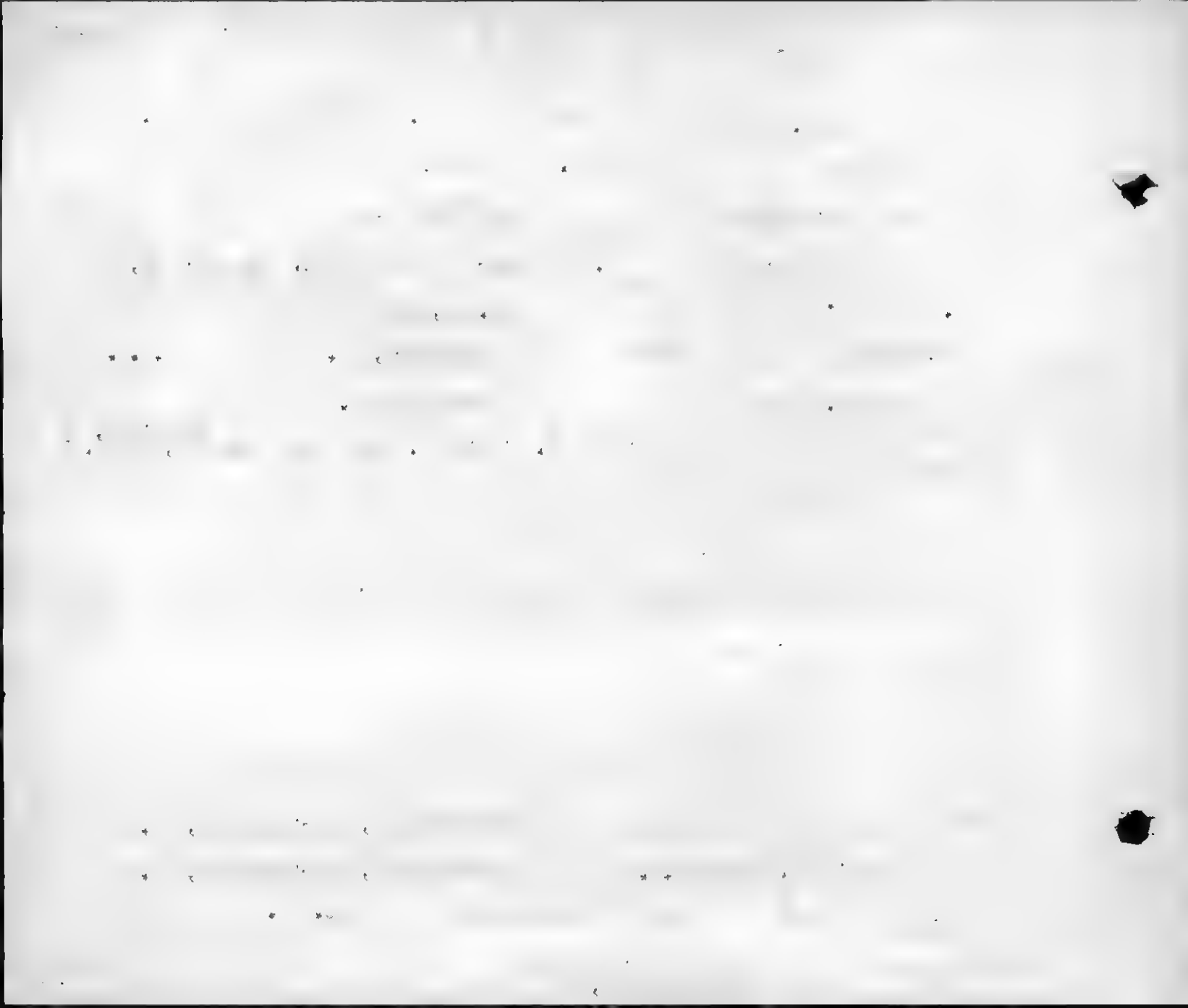
## CERTIFICATE OF DEATH

11190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3400 Abbie Place</b>		d. STREET ADDRESS <b>2208 Pine Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>O.</b> Last <b>Weber</b>		4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>Dec. 14, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Lynchburg, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse W. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna A. ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Mr. William L. Weber</b>		Address <b>2208 Pine Ave, Balto. 7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331 X</b> DUE TO (b) <b>Arteriosclerosis + hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 21, 1959</b> to <b>Oct 21, 1959</b> , that I last saw the deceased alive on <b>Oct 21, 1959</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. E. Martin</b>		ADDRESS (Street, city or town, state) <b>Liberty Road, Harrisonville, Md.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>William E. Martin M.D.</b>		<b>Liberty Road, Harrisonville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Myers</b>		ADDRESS <b>8728 Liberty Road Randallstown, Md</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.



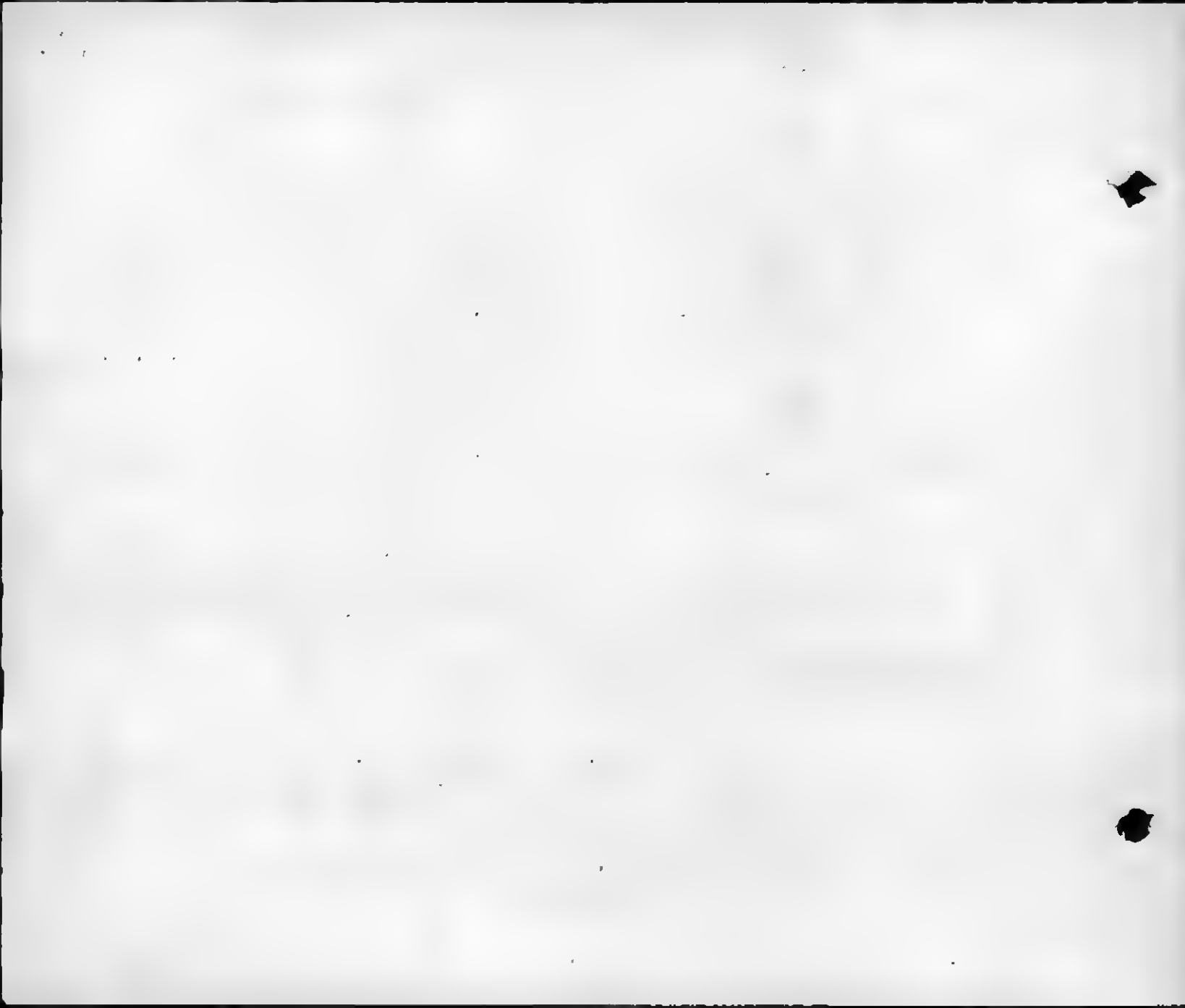
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11211 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11211 CERTIFICATE OF DEATH

11191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13yr26dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>	
3. NAME OF DECEASED (Type or print) <b>May</b> First Middle Last <b>West</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb. 25</b> , 19 <b>59</b> , to <b>Oct. 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 23</b> , 19 <b>59</b> , and that death occurred at <b>3:30a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>10-23-59</b>	
PHYSICIAN'S NAME (Type) <b>Bruno Radauskas, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## 11212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

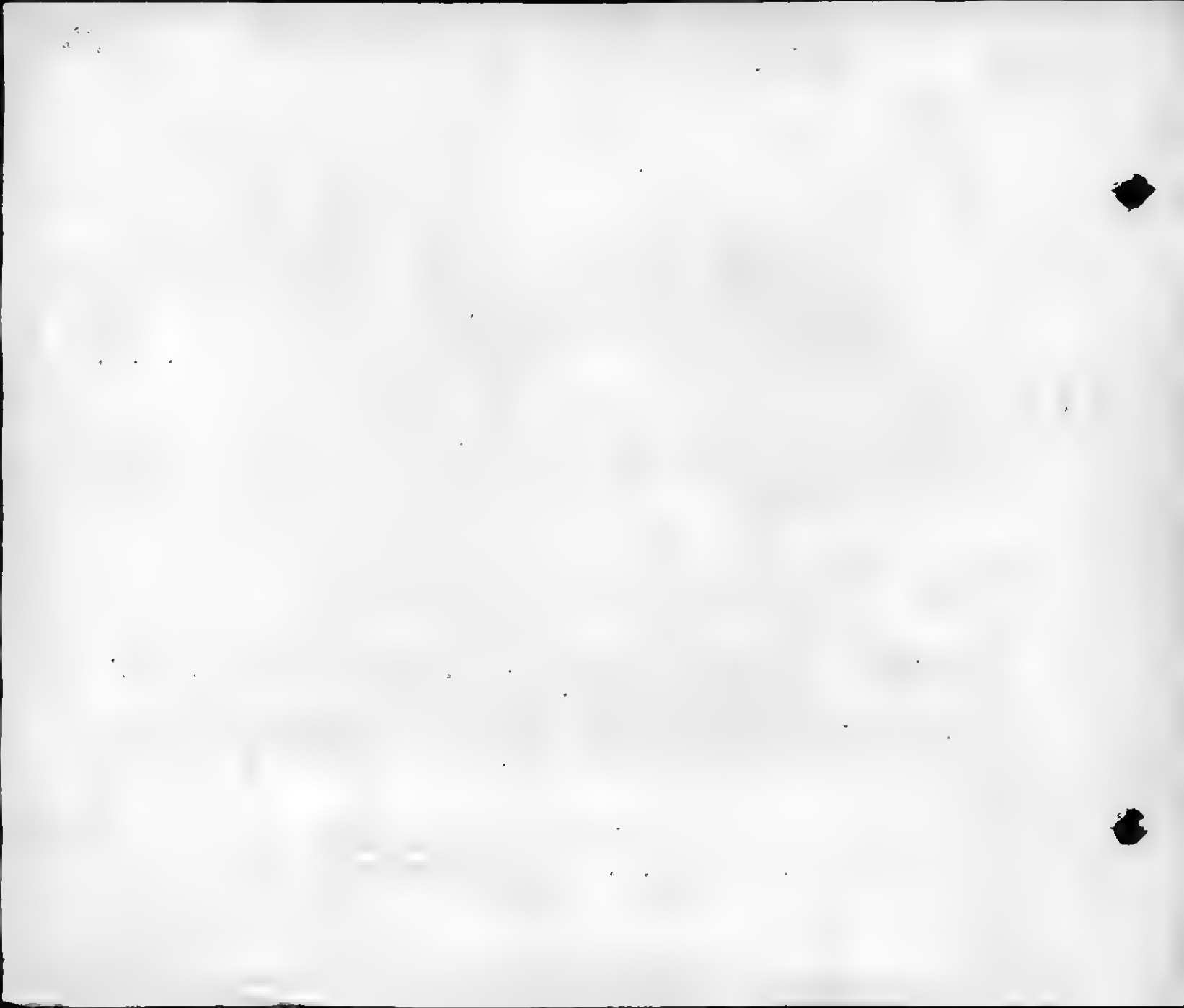
Item 9 FilmG251 10-30-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>2mth24dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1311 West Pratt Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>M.</b> Last <b>Wheeler</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1881</b>
9. AGE (In years last birthday) <b>77 78</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown NO</b>		16. SOCIAL SECURITY NO. <b>None Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.1 DUE TO</b> <b>LANGRENE OF LEFT LOC.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIO SCLEROSIS</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) on <b>8-6-59</b> pt. fell to floor on way to bathroom, sustaining a subcapital fracture of the left femur. 20c. TIME OF INJURY Month, Day, Year Hour <b>10:45</b> p.m. <b>8-6</b> 19 <b>59</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b> 20f. (City or town) (County) (State) <b>Catonsville, Maryland</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George M. Kieffer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>28 Oct 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Woodbine Carroll Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>For Mr. B. M. Walker</b>		24a. REC'D BY REGISTRAR <b>Patricia Sticker</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>		DATE <b>OCT 26 '59</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11213

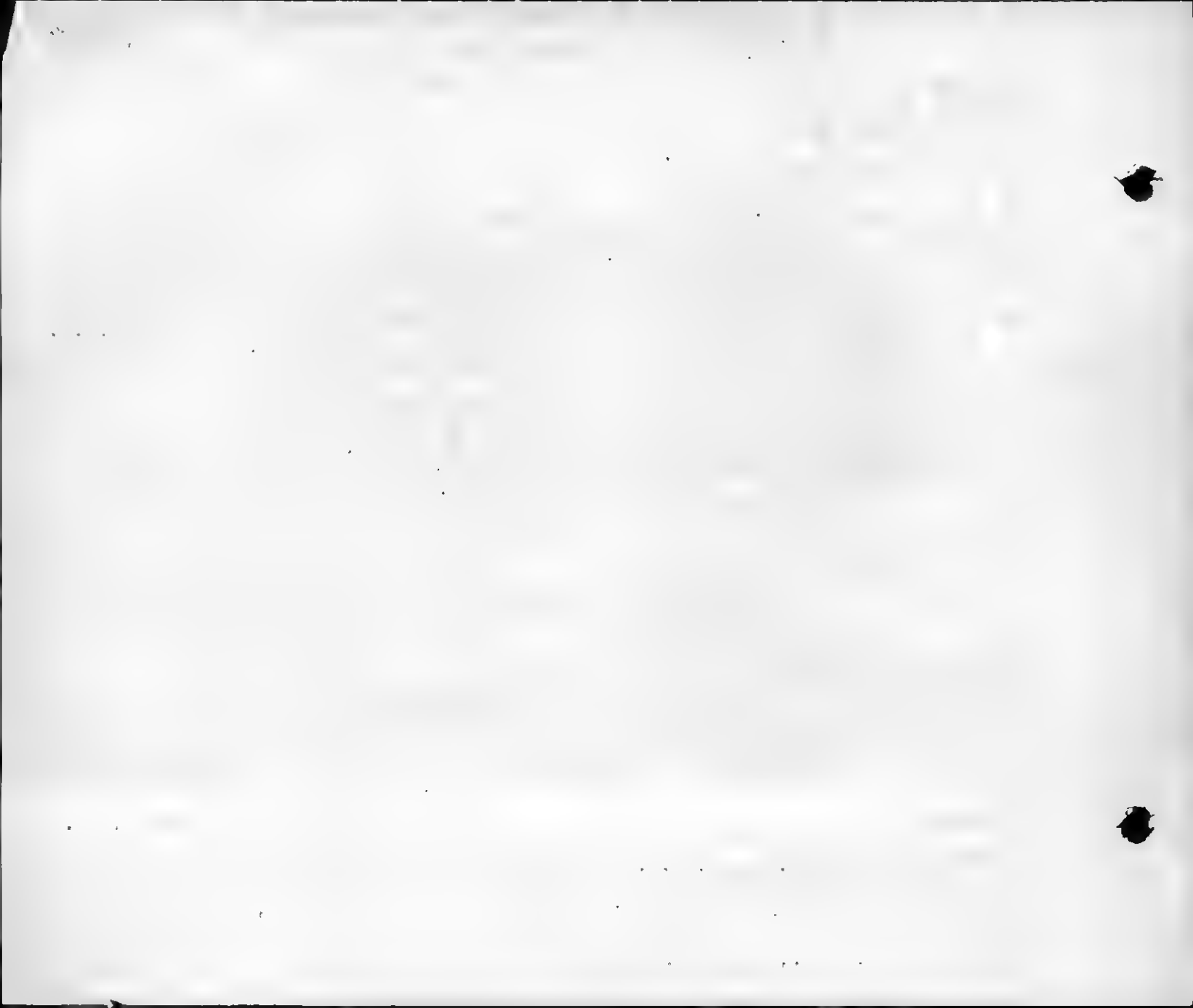
## CERTIFICATE OF DEATH

11193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>2025 R ST.</b> b. COUNTY <b>WASHINGTON DC</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>2 yrs 8 mo 15 d</b>		d. STREET ADDRESS <b>2025 R ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood Sanatorium Towson 4, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rufus N W HITLEY</b>		4. DATE OF DEATH Month <b>OCT</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 5 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>HARDMAN COUNTY TENN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rufus V. W HITLEY</b>		14. MOTHER'S MAIDEN NAME <b>MARGIE HARMON</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Personal History</b>		Address <b>Hospital Records, Eudowood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-10-57</b> , 1957, to <b>OCT 25</b> , 1959, that I last saw the deceased alive on <b>OCT 25</b> , 1959, and that death occurred at <b>10:15</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Milton B. Kress, M.D.</b>		Eudowood Sanatorium - Towson 4, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>REMOVAL</b>		<b>10-27-59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Oaklawn Cemetery</b>		<b>Jonesboro, Arkansas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>William Cook, Inc., 1217 St. Paul Street</b>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>OCT 27 1959</b>		<b>C. H. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

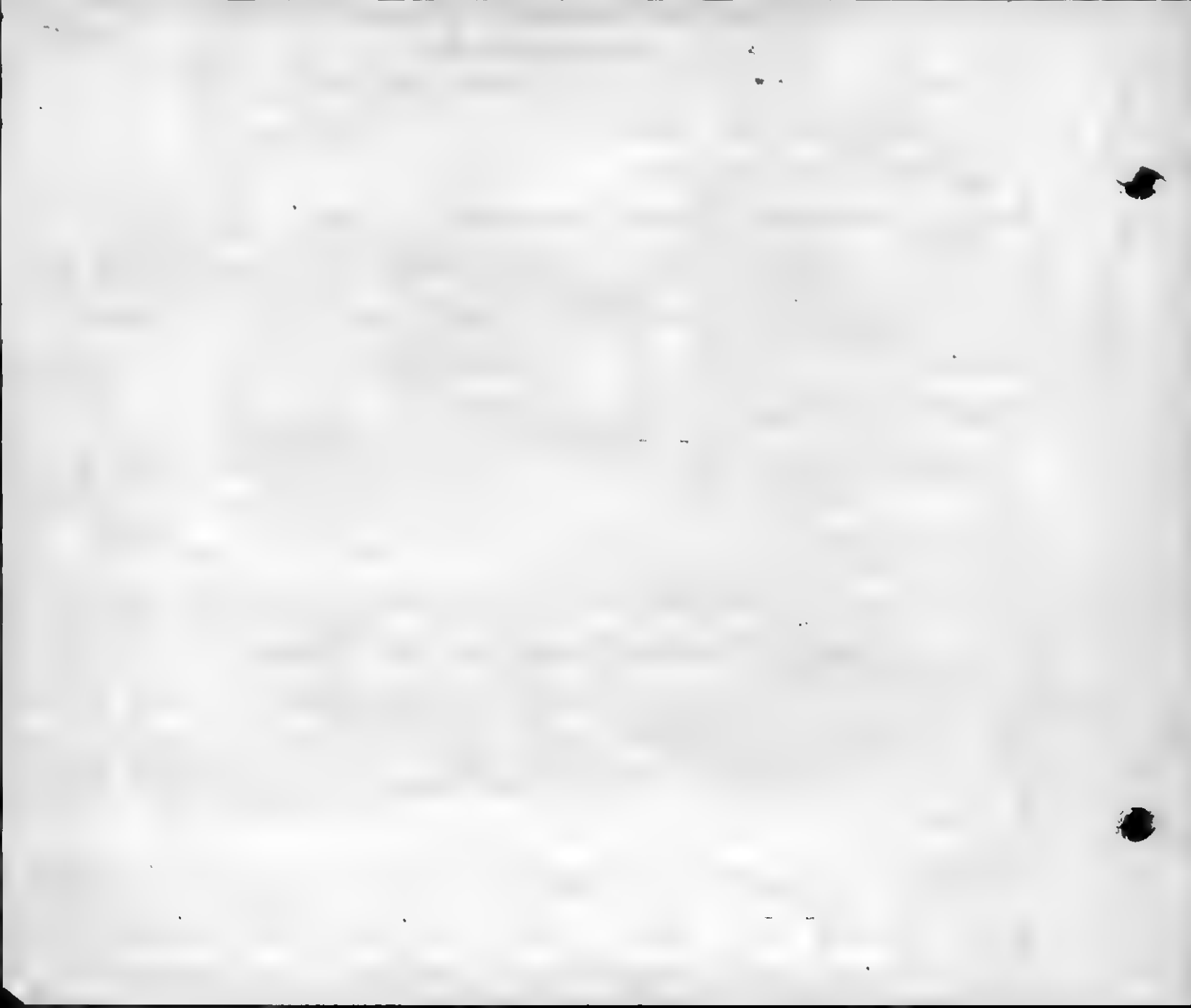
11214

## CERTIFICATE OF DEATH

11194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>				d. STREET ADDRESS <u>3402 Upton Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Corrad</u> First <u>Wilhelm</u> Middle Last				4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Carl Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Emma Worf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-07-1774</u>			
17. INFORMANT Address <u>Mrs Elizabeth Wilhelm</u> same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 12, 1959</u> , to <u>Oct 18, 1959</u> , that I last saw the deceased alive on <u>Oct 18, 1959</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis Senceroff</u> M.D.				ADDRESS (Street, city or town, state) <u>2106 Chesapeake Rd Baltimore, Md.</u>			
DATE SIGNED <u>10/18/59</u>							
PHYSICIAN'S NAME (Type) <u>Louis Senceroff</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinne</u>	



11215

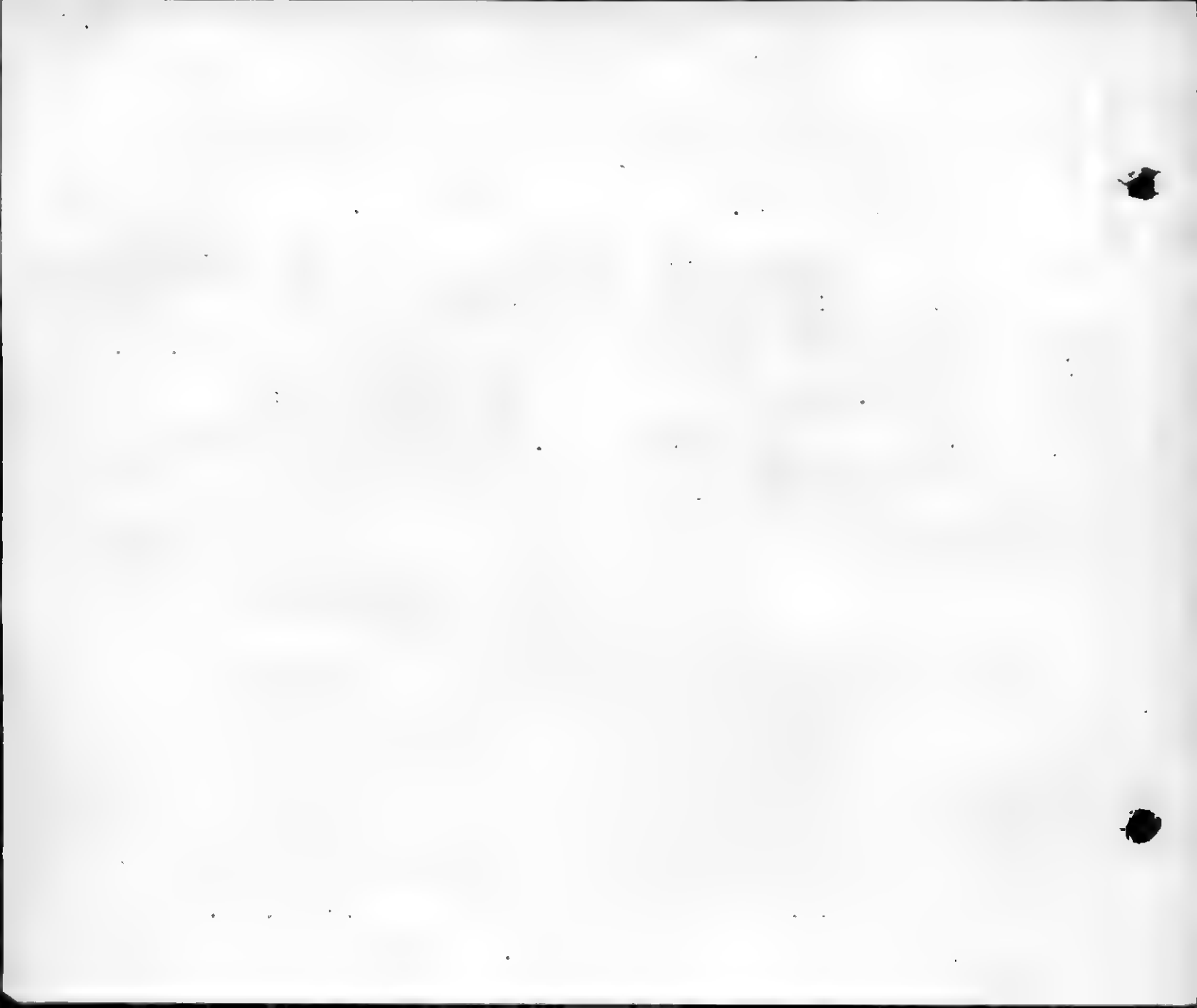
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton (rural)</b>		c. LENGTH OF STAY IN IB <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Bosley</b> Last <b>Wilhelm</b>		4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel W. Bosley</b>		14. MOTHER'S MAIDEN NAME <b>Winifred Miles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>W. Webster Wilhelm,</b>		Address <b>above</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast - recurrent metastatic</b> DUE TO (b) <b>110X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 1958, to <b>Sept 5</b> , 1959, that I last saw the deceased alive on <b>10-4-59</b> , 19, and that death occurred at <b>10:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Herbert Mueller Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>10/7/59</b>	
PHYSICIAN'S NAME (Type) <b>C. HERBERT MUELLER JR.</b>		<b>HEREFORD, PARKTON P.O. MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-8-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bosleys Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Oct 9 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11216

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>135 Slade Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Esther Bixler Wisner</b>				4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1883</b>	9. AGE (In years last birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Theodore Bixler</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Royer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Miss Thelma Wisner 135 Slade Avenue, Pikesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Coronary sclerosis</b> (c) <b>Art. Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>6 mos.</b> <b>2-3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension - 10 yrs.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>48</b> , to <b>Oct 11th</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 10th</b> , 19 <b>59</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James S. Miller</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>1331 Reisterstown Rd Pikesville, Maryland 10/12/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James Miller</b>				<b>Pikesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 4 Filed 10-14-59 et

11217

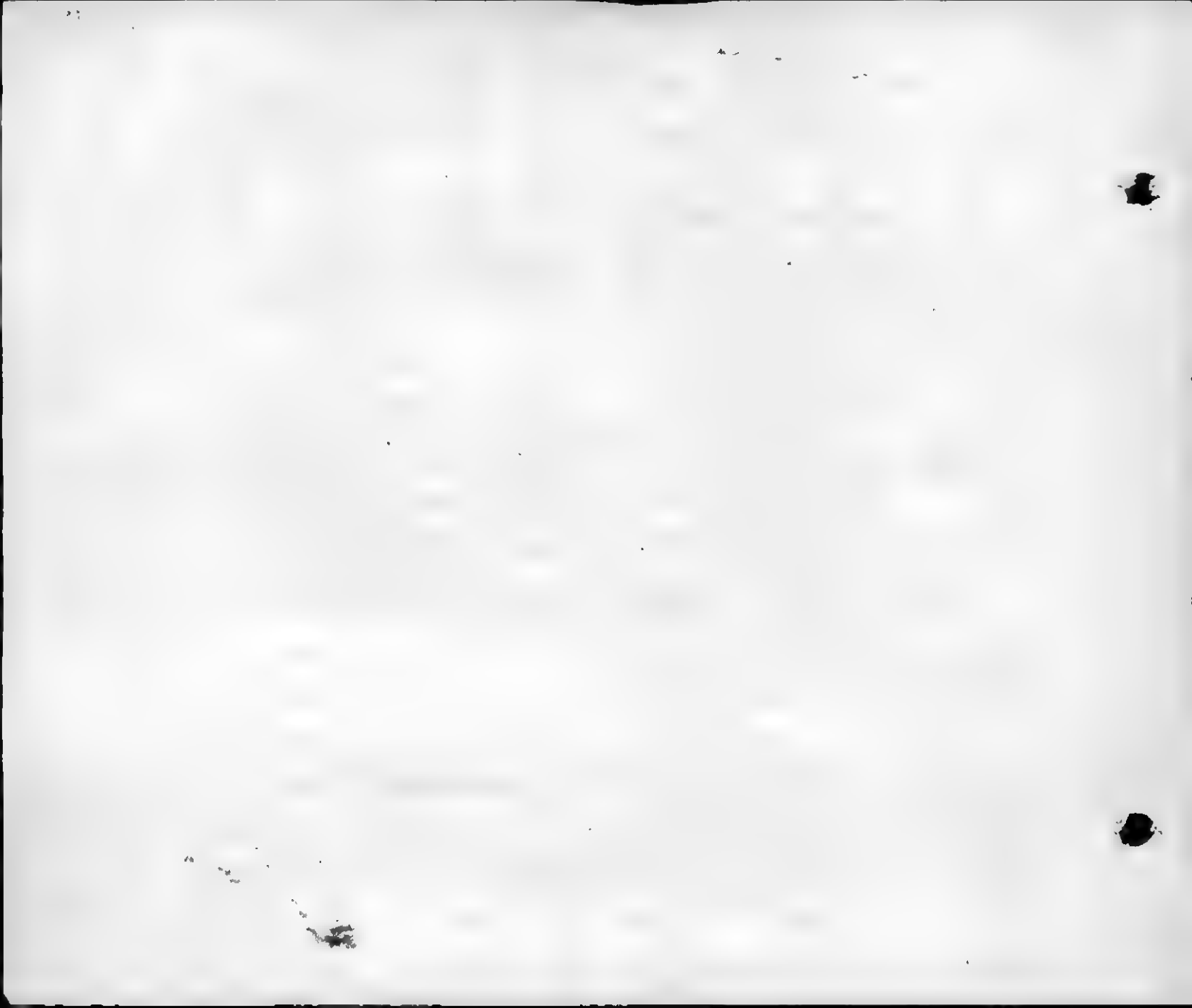
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>		d. STREET ADDRESS <u>524 Wilton Road</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>R. WOOLMER</u> Middle Last		4. DATE OF DEATH <u>October</u> <u>9</u> , 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James R. Woolmer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Creamer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>064-09-2265</u>	
17. INFORMANT <u>Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma of Penis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>7-10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 9, 1959</u> to <u>Oct 9, 1959</u> , that I last saw the deceased alive on <u>Oct 9, 1959</u> , and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>2501 York Rd</u> DATE SIGNED <u>10/10/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		Towson, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 12, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>David Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Rd</u>	
24b. REC'D BY REGISTRAR <u>OCT 13 '59</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





11218

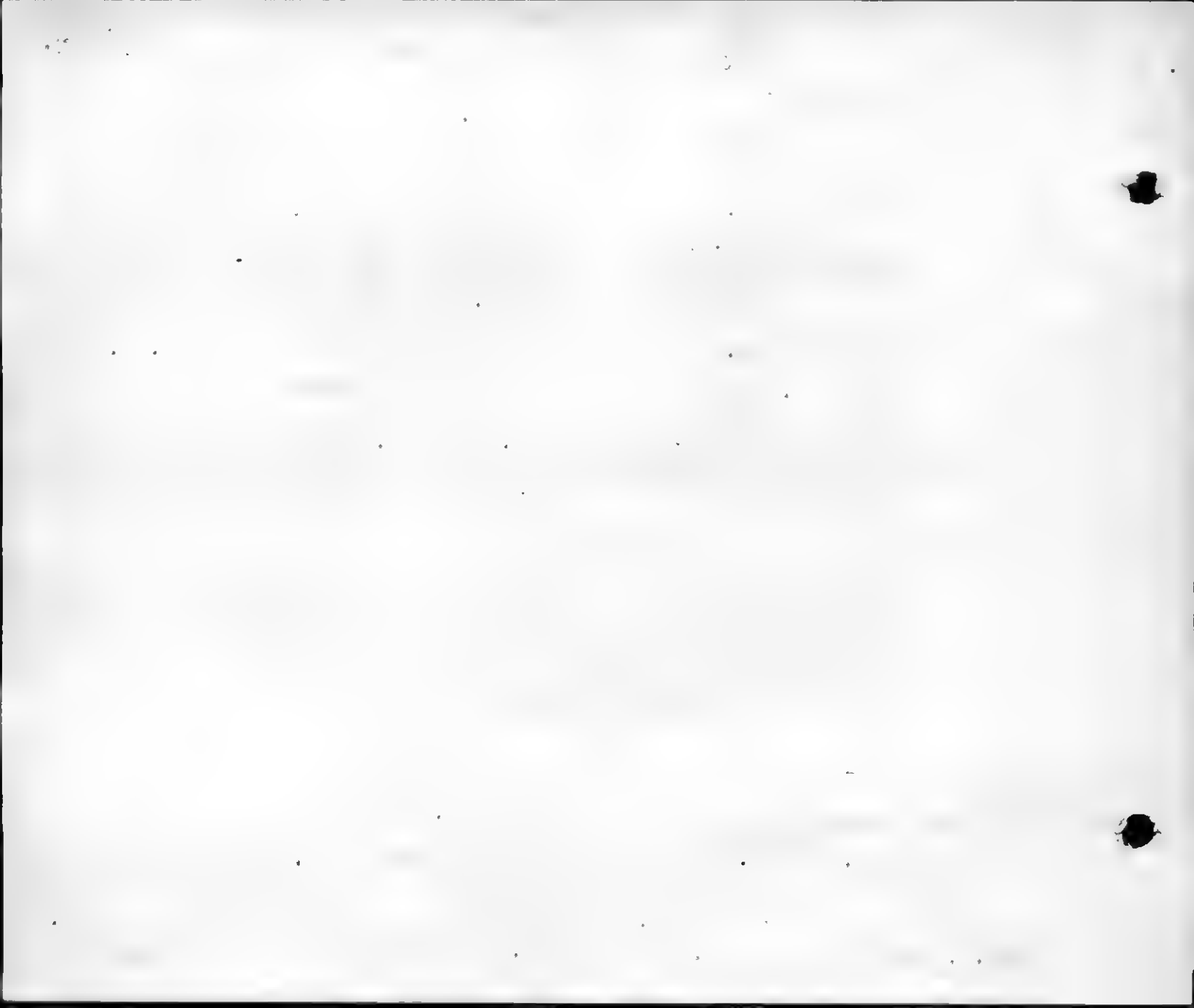
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1725 Circle Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Barhyte</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive (Vice Pres.) Steamship</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arthur S. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Julia Barhyte</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>212-10-2532</b>	
17. INFORMANT <b>Mrs. Polly B. Wright</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastases from carcinoma of the lung</b> DUE TO (b) <b>Carcinoma of the lung</b> DUE TO (c) <b>14 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , 19____, to <b>death</b> , 19____, that I last saw the deceased alive on <b>10-15-59</b> , 19____, and that death occurred at <b>9:45 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Warde B. Allan</b> M.D.		ADDRESS (Street, city or town, state) <b>6 E. Eager Street</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Warde B. Allan</b>		<b>Baltimore 2, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas' Church</b>	22d. LOCATION (City, town, or county) (State) <b>Garrison Forest Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		24a. REC'D BY REGISTRAR <b>4905 York Rd. 12</b>	
24b. REGISTRAR'S SIGNATURE <b>OCT 29 1959</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22B, Film 6210 10/22/59 1wk

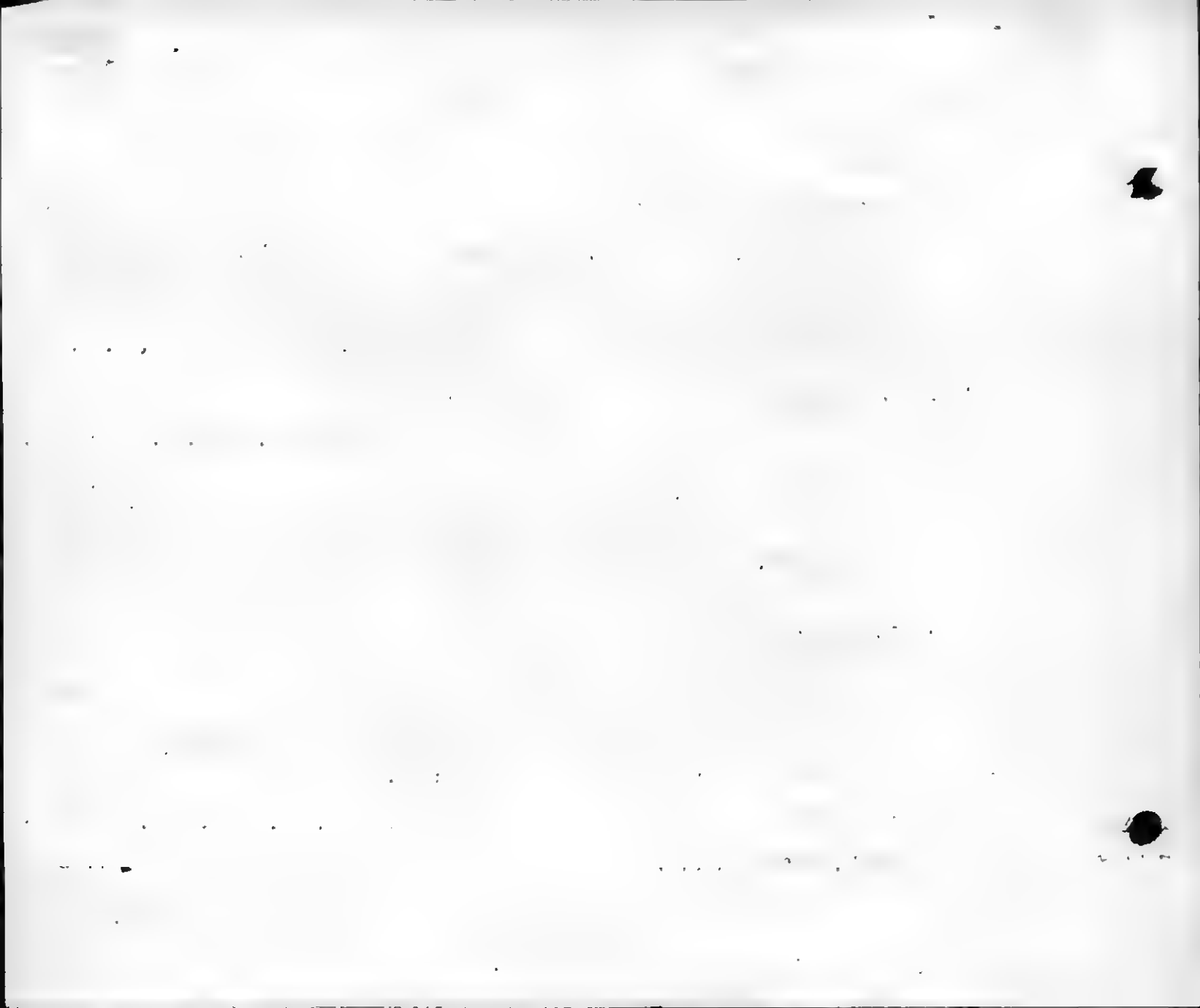
## CERTIFICATE OF DEATH

Reg. Dist. No.

11199

11219

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>203 Belvedere Avenue</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM S. WRIGHT</b>						4. DATE OF DEATH Month Day Year <b>October 15, 1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 6, 1880</b>		9. AGE (In years lost birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Company</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William C. Wright</b>						14. MOTHER'S MAIDEN NAME <b>Emma V. Webster</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes SAW</b>				16. SOCIAL SECURITY NO <b>Unknown</b>		INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PYELONEPHRITIS</b> <b>ARTERIOSCLEROSIS OF AORTIC AND MITRAL VALVES</b> <b>DILATATION AND HYPERTROPHY OF HEART, LEFT VENTRICLE</b> <b>ARTERIOSCLEROSIS, GENERALIZED</b> <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BLEEDING RECTAL POLYP</b>										INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VA</b>		(County) (State)	
21. I certify that I attended the deceased from <b>October 8, 1959</b> to <b>October 15, 1959</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, BALTO. 18, MD., FT. HOWARD DIV. 10/16/59</b>											
ACTUAL SIGNATURE <i>John W. Crawford</i>				M.D. <b>VAH, BALTO. 18, MD., FT. HOWARD DIV. 10/16/59</b>							
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR <b>Oct 19 59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Adams</i>			
24c. REGISTRAR'S SIGNATURE <b>Howard H. Hubbard</b>											



## CERTIFICATE OF DEATH

Reg. Dist. No.

11260

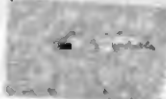
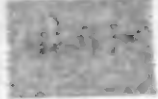
11220

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>17 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>I.</b> Last <b>ZEPP</b>		4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter and Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Hampstead, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William H. Zepp</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Sprinkel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md., FORT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ABDOMINAL CARCINOMATOSIS, GENERALIZED</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PRIMARY CARCINOMA OF KIDNEY, RIGHT</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>L. Pyelonephritis, bilateral. Status post abdominal perineal resection</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 3, 19 59, to October 20, 19 59</b> and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John W. Crawford</b> <b>10/20/59</b> M.D. <b>JOHN W. CRAWFORD</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Snydersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tipton Funeral Home, Hampstead, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11201

110M

## MEDICAL CERTIFICATION

VS. A15ME(5)  
SM 9/55

1901

RECEIVED FROM THE MEDICAL EXAMINER'S OFFICE - DEATH

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Occupation", "Cause of Death" are faintly visible.]*